OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY OF VIRGINIA

VIRGINIA MEDICAL MONTHLY

Contents

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Guest Editorial — 1
You and Your A.M.A. — 2
Antihistaminics — 8
Anemia — 12
Treatment of Intestinal Obstruction with the Air-Vent Tube — 17
The Practical Management of Alopecia — 20
Administration of Potassium to Surgical Patients in a 150 Bed Hospital — 25
Geriatrics Unlimited — 29
Multiple Osteochondromata of the Hand — 36
Eosinophilic Granuloma of the Skull; Report of Four Cases of a Benign Bone Lesion — 38
Electro Shock Therapy—Central State Hospital — 44

(Continued on page 6)

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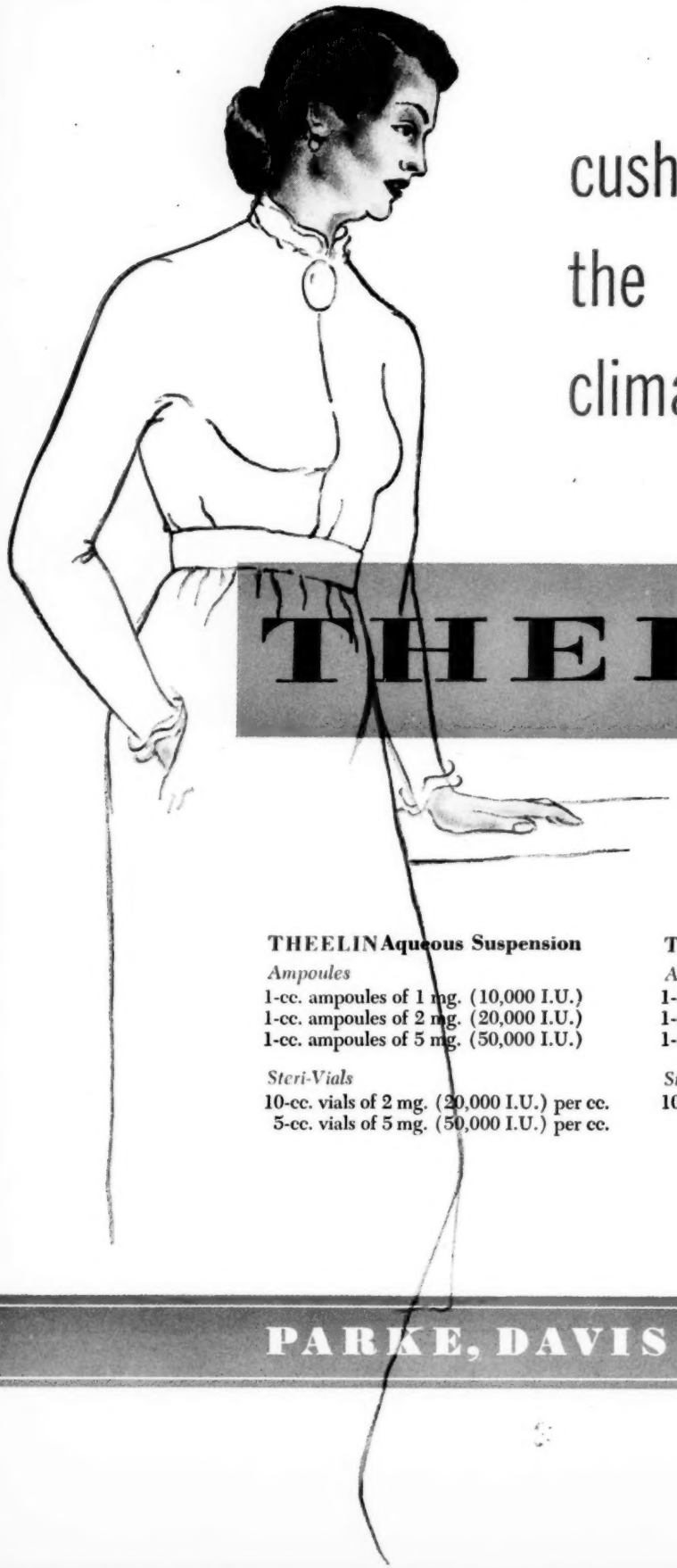

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GUEST EDITORIAL

Looking Ahead in Public Health

THE Public Health movement launched in 1848 passed its one-hundredth birthday in 1948. At the end of a century, it is worthwhile to review what has happened as a result of advances in medical science and in sanitary and hygienic services. Even though the century has experienced two world wars of unparalleled destructiveness, the century has also witnessed unparalleled achievements in medical science and in the practical application of the principles of preventive medicine and public health. In listing a few of these achievements, we find a decrease in infant and maternal mortality, and the practical elimination of mortality from certain of the communicable diseases. As a result, life expectation has been increased by some twenty-five years for males and twenty-seven years for females in the past 100 years.

Holding the gains already made, both practicing and public health physicians find themselves turning attention to other problems. Among these unsolved problems in the field of prevention and cure are those of cancer, the increase of mental derangements, poliomyelitis, the cardio-vascular lesions, accidents in the home, on the job or from motor cars and the underlying conditions leading to the rising incidence of suicides, homicides and alcoholism.

One hundred years ago many of these problems would have been thought of as outside the purview of public health but today the concept has been enlarged to embrace whatever concerns the physical and mental fitness of the population.

Public Health, as a branch of the profession of medicine, has shown marked advances in the past quarter of a century. Increasing emphasis is being placed on the personal fitness and professional capacity of physicians entering Public Health as a profession. Recently the American Board of Preventive Medicine and Public Health has been organized to encourage the study, improve the practice and advance the cause of preventive medicine and public health. In the issue of the Journal of the American Medical Association for September 29, 1951, the Council on Medical Education and Hospitals of the American Medical Association published the list of approved residency training programs in Preventive Medicine and Public Health in thirty-nine local areas in thirteen states. One of the approved programs was the Arlington County Health Department in Virginia.

In the thinking, planning and performance in this enlarged field of Public Health, I and my colleagues in the Virginia Health Department—State and local—feel privileged to work with the practicing physicians of the State. The assurances that have come to me of the fine spirit of comradeship and cooperation which has existed over the years between the State Health Department, The Medical Society of Virginia and the practicing physicians of the State, make all the keener my anticipation of a satisfying experience of service in public health in Virginia.

MACK I. SHANHOLTZ, M.D.,
State Health Commissioner of Virginia

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YOU AND YOUR A.M.A.

WALTER B. MARTIN, M.D., *Moderator*

At the meeting of The Medical Society of Virginia at the Cavalier Hotel, Virginia Beach, Monday, October 8, 1951, the speakers in this discussion were presented by Dr. Martin of Norfolk, member of the Board of Trustees, American Medical Association.

WHY YOU AND YOUR A.M.A.

H. B. MULHOLLAND, M.D.,
Member, Council on Medical Service, A.M.A.
Charlottesville, Virginia.

The Council on Medical Service and the Board of Trustees of the American Medical Association decided to inaugurate a series of "trial runs" in several states in an endeavor to acquaint the state societies with some of the functions of the Headquarters group and its various Councils and Committees. Virginia was picked as one of the states for this co-operative effort to educate the doctor about his National organization.

My particular phase of this overall picture is to briefly outline to you the work of the Council on Medical Service, whose function is "To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people". Several years ago this Council established eight committees to work with its members. Each one of these committees consists of five to eight members selected because of their interest or work in some phase of medical service or medical care and with due regard to representation of various geographical areas. On each one of these committees, there is a member from the Council on Medical Service. These groups are constantly engaged in studying and formulating principles and plans for all types of medical service.

A short resume of the function of each Committee follows:

COMMITTEE ON PREPAYMENT HOSPITAL AND MEDICAL SERVICE

This committee has under consideration all matters pertaining to the evaluation of voluntary prepayment medical care plans; and to the evaluation of voluntary health insurance written by private insurance carriers.

The "Seal of Acceptance" has become known to all interested in prepayment insurance, and this committee carefully screens all applications before such approval is given to any plan.

Besides the above functions, there is always under consideration the important possibilities of increasing the scope of the benefits under all types of voluntary health insurance. Several meetings have been held both nationally and regionally, with all interested groups holding a full discussion of all of the above problems.

The Voluntary Prepayment Medical Care booklet which is annually revised and published is an effort of this committee.

COMMITTEE ON EXTENSION OF HOSPITALS AND OTHER FACILITIES

Perhaps the best known activity to come out of this committee to date is "The Report of the Committee on Hospitals and the Practice of Medicine", the so-called "Hess" report, which is concerned with the physician-hospital relationship.

The question of the impact of facilities constructed under the Hill-Burton Act also receives constant consideration of this group, and the auxiliary facilities, such as health centers, medical service centers, out patient dispensaries being developed throughout the country are constantly under its surveillance.

One of its recent activities is to implement the recent action of the Board of Trustees in expanding and developing the Physicians Placement Service, for which purpose a meeting of all of the states with sound functioning programs was held in Chicago in October.

COMMITTEE ON INDIGENT CARE

Indigent care is an all important problem involving the delivery of medical service. This committee is now engaged in making a survey of the various indigent care plans throughout the country, their relationship to state and local medical societies, with a view to establishing basic principles for the operation of these programs, the development of minimal standards for these plans, and preparation of guides for the operation of different types of plans tailored to fit local patterns. Liaison between the American Public Health Association and the American Public Welfare Association has already been established in this connection.

COMMITTEE ON MATERNAL AND CHILD CARE

It is the purpose of this committee to concern itself with the A.M.A. activities in the above field together with compilation of data on the problems in this area and the development of programs adaptable for local areas in coordination with state and local societies.

However, of immediate concern is a discussion of a possible revival of the E.M.I.C. program. The committee sampled groups of physicians which resulted in obtaining data about the working of this plan in World War II, its good and bad points. Several meetings with pediatric, obstetrical societies, American Legion, and the Children's Bureau were held and a broad discussion of the subject ensued.

It is now the opinion of this committee that a revival of this program at this time is not necessary.

COMMITTEE ON MEDICAL CARE FOR INDUSTRIAL WORKERS

To answer many of the questions foremost in the minds of those interested in these problems, the committee is now concerned with a review of the scope of medical care programs now available to industrial workers, how broad the term "industrial worker" should be, the status of physicians engaged in these medical care programs, and medical school teaching in these problems.

Cash sickness benefits with its enabling legislation is being studied. A comprehensive report on this subject was rendered to the House of Delegates of the A.M.A. in June, 1951.

COMMITTEE ON FEDERAL MEDICAL SERVICES

This recently activated committee will study the many subjects relating to medical and hospital care of veterans, Federal programs for medical care, home town medical care, and establish the necessary liaison with all groups concerned.

COMMITTEE ON RELATIONS WITH LAY SPONSORED VOLUNTARY HEALTH PLANS

Since its inception, the committee has been busy with annotating the "Twenty Principles" for lay sponsored voluntary health plans, which provides sound practice for the operation of so-called "Co-ops". It will pass on and evaluate any plans developed under these auspices and screen all applications for approval. An attempt has been made to form a liaison with these groups.

From the above, it can be gathered that this Council has under active consideration the broader aspects of medical care and service, including studies and plans for the improvement and expansion of such service by physicians to the people of the United States of America. Indeed, this involves care from the "cradle to the grave".

THE A.M.A. BEGINS AT HOME

JOHN T. T. HUNDLEY, M.D.
President-Elect, The Medical Society of Virginia.
Lynchburg, Virginia.

The individual doctor constitutes the A.M.A., and it is he who benefits from the activities of the A.M.A.

The *Fasces* was an old Roman emblem. It indicated strength through unity. Recent events in world history attributed unhappy connotations to the Fascist emblem, but the emblem itself, a binding together of a number of weak reeds, to create great strength through unity, is as meaningful as ever. It is by such a binding together of weak individuals that the strength of the A.M.A. is derived.

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As individual doctors we mean little except to ourselves, our families, and a few patients.

As a nation-wide, cohesive organization of highly trained professional men and women, we exert tremendous strength.

That strength is used to extend medical knowledge, to correlate medical efforts, to distribute and expand medical services, to protect the public from charlatans and imposters, to guide and inform legislators toward the wise enactment of laws affecting the practice of the healing arts, to protect us and our patients from dangerous encroachment on our rights and privileges.

The A.M.A. primarily functions on a national level, but those functions, nationally conceived and applied, have direct and personal concern over the lives and professional activities of each of us.

It is through and from us that the A.M.A. receives its strength, and it is we as individuals, and our local communities, that profit from that strength. Failure to support the A.M.A. is comparable to failure to support our parents, or our children.

You are the A.M.A.

YOU ARE THE A.M.A.

LOUIS H. BAUER, M.D.,
President-Elect, American Medical Association,
Hempstead, New York.

Probably no organization in the world has done so much for its members, nor is regarded with such indifference by a portion of its membership as the American Medical Association.

There is an old saying that one never appreciates what one does not pay for, and this in part explains the situation, for until 1949, no member was asked to pay any dues and then only on the basis of a voluntary assessment. In 1950, dues were made mandatory. While the vast majority of members paid these dues, there were a number who flatly refused and others who failed to do so, chiefly because they had too little knowledge of what the A.M.A. is and has done for them.

One of the canards against the A.M.A. that one frequently hears is that it is run by a small hierarchy. The very nature of its organization makes this impossible. The A.M.A. is wholly democratic and other organizations, notably the American Bar Association, have patterned their structure on it.

There are 2,011 component County and District societies, organized into 53 constituent associations in the States, Territories and Possessions.

The whole membership of the County and District Societies elect delegates to the constituent associations. These delegates in turn elect delegates to the A.M.A. House of Delegates. These delegates are elected for two year terms only, about half of these terms expiring each year. Therefore, it would be possible to change completely the complexion of the A.M.A. House of Delegates within two years.

The House being in session only twice a year delegates much of its authority to a Board of Trustees, nine in number, plus the President and President-Elect. Each Trustee is elected for 5 years and can serve a maximum of two terms. I was first elected to the Board of Trustees in 1944. When I was made President-Elect in June, 1951, there was not a single member of the Board who was on it when I was first elected. What sort of a hierarchy is that?

When the House of Delegates meets, any member of the A.M.A. can attend its sessions. Any member can appear before any of the Reference Committees to which all reports and resolutions are referred before being considered by the House. He can support, attack or suggest amendments to any piece of legislation, and he will be listened to with respect and his views carefully considered. Not many members who are not members of the House take the trouble so to appear, but that is not the fault of the A.M.A. It is the fault of the members. The House of Delegates is not going to adopt any policy or any regulation which it knows the majority of its members oppose. Congress endeavors to keep its ear attuned to the wishes of its constituents, and many pieces of legislation pass or fail because of the demands of the citizens. Just so you can make your desires known and felt in the Congress of the A.M.A.,

namely, its House of Delegates.

You are the A.M.A. and if you do not approve of all it does, and if the majority of your associates agree with you, it is because you have not taken the trouble to make yourselves and your opinions known.

Of course, in any organization as large as the A.M.A. there must be and should be differences of opinion. The majority rules. The minority must adhere until it can persuade the majority that a change should be made. Work from within the association and not from without it.

What are some of the things the association does for you as an individual member?

First, there is the Council on Medical Education and Hospitals. This was originally established to improve the quality of medical education. As a result of the Council's activities the standards of medical education in this country have been raised to a level unsurpassed anywhere in the world. Diploma mills and second rate schools have been abolished. The fact that each one of you is a graduate of an acceptable medical school is due to the A.M.A. The Council also surveys hospitals and technical schools. Residency and intern programs must meet rigid standards to meet approval.

Now that the American College of Surgeons is about to relinquish its surveys of hospitals for other professional standards this program is to be carried on jointly by the American Medical Association, the American College of Surgeons and the American College of Physicians and the American Hospital Association. There will be one inspection instead of two or three.

The Council also acts in collaboration with the various Specialty Boards.

The Council on Pharmacy and Chemistry was organized to protect the profession and the public against quackery and worthless products. Any product approved by the Council is one the physician and the public can rely upon. In connection with this Council is the Therapeutic Trials Committee and the Chemical Laboratory.

The Council on Foods and Nutrition acts in the same capacity in its field.

The Council on Physical Medicine and Rehabilitation disseminates information on the therapeutic and diagnostic value of certain devices and methods employed in medicine.

The Bureau of Investigation is a constant watch dog against quacks, charlatans and nostrums. The Federal Trade Commission uses much of the information compiled by this Bureau.

The Bureau of Exhibits plans scientific exhibits for the meetings of the Association which are a post-graduate course in themselves. These exhibits are often loaned to State Associations for their meetings.

The Library of the Association has a general reference lending library available to any member without charge.

The Council on Scientific Assembly plans the Scientific programs in collaboration with the various scientific sections for the annual and interim sessions.

The Bureau of Legal Medicine and Legislation analyzes all medical legislation, both Federal and State, and promulgates court decisions of interest to physicians.

The Council on Industrial Health has done much to improve the Standards of health in industry.

The Council on National Emergency Medical Service is in the forefront of both military and civil defense and has been active in seeing that physicians in military service are not wasted on non-medical jobs.

The Bureau of Medical Economics Research is constantly studying and issuing information on subjects pertaining to the economics of medicine.

The Bureau of Health Education has a tremendous program for education of the laity in health matters and publishes a magazine for the laity, entitled, "Today's Health".

There is the Council on Medical Service about which you have heard much today and it is a most active council. It keeps you informed of the social and economic changes in the problems of medical care and endeavors to find ways of improving the distribution and methods of medical care. It has several sub-committees and has done a great deal in the field of voluntary insurance.

The Washington office of the Association keeps in touch with the various Federal agencies and with Congress. It keeps them informed on the opinions of the profession and also keeps in close touch with legislative activities in the field of health and informs State and County Associations of these activities.

The Committee on Rural Health keeps in close contact with farm organizations and is constantly striving to improve medical care in the rural areas.

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The Judicial Council is a sort of Supreme Court of the medical profession on matters of membership and professional ethics.

The scientific publications of the Association, the *Journal of the A.M.A.* and nine special journals, are familiar to you all and they are outstanding in the field of medical journalism.

The Department of Public Relations is being reorganized and expanded. It has organized an Advisory Committee and will cooperate closely with State Associations. It publicizes all the activities of the various departments of the Association. Its aim is to build good will for the medical profession in order to advance the health and welfare of the people.

There are various other departments concerned with administration, membership and finance, including the Biographical Department which keeps record of all physicians and medical students.

To house all these departments and personnel necessary to carry on their activities the Association has a nine story building occupying two-thirds of a city block and over 800 employees are on the pay roll. The whole environment of the practice of medicine today is a result of the activities of the A.M.A. The fact that you can practice good medicine unhampered, and protected by the activities of all of these Councils and Bureaus you owe to the A.M.A.

The Association's activities have expanded so much that no longer can its publications support its financial demands.

The members are now asked to pay $25 a year for their membership. This includes subscription to the Journal which in itself costs $15. Hence, you are really asked to pay $10 a year for the privilege of membership. Is that a great sacrifice? Considering what is being done for you, is it not more than reasonable? Do you not owe it to both yourself and to the protection of high medical standards to maintain your membership?

Remember YOU are the A.M.A. If there is anything about it you do not like, get in and be active and work for the changes you think should be made. Do not stand to one side and merely criticize.

QUESTIONS ANSWERED BY DR. BAUER

Q. What is the American Medical Education Foundation and what is the reason for its existence?

A. The American Medical Education Foundation is a non-profit organization founded to receive and distribute contributions to medical schools. This Foundation endeavors to obtain funds from physicians and medical societies. It works in close cooperation with the American Medical Education Fund, which endeavors to obtain funds for the same purpose from business organizations and lay individuals.

Our medical schools are in dire financial straits. It has been proposed that the Federal Government contribute the necessary funds. The A.M.A. is opposed to this except that it recommends a one-time Federal grant for construction and modernization of medical schools. The Association feels that while the Federal Government now makes grants-in-aid to medical schools, these grants are for specific purposes and form only a small part of the income of medical schools. Should Federal aid reach the point where the majority of the funds for medical education came from the Federal Government, there is grave danger of government control of medical education. Furthermore, the acceptance of Federal aid would result in the drying up of private funds now being contributed. The schools in a few years would be entirely dependent on Federal money in order to continue operation. A withdrawal, then, of such Federal aid would leave the schools in a worse predicament than they are now. In case of a depression or an all-out war, Federal funds might well be curtailed. Likewise, the Association feels that sources of private funds are not yet exhausted.

No doctor ever paid for his medical education. The student or his family paid only the tuition but the actual cost to the school is several times the amount of the tuition. These additional funds have come from endowment. The doctor now has a chance to pay his debt. This he can do by contributing to the Foundation, either in an unrestricted gift or by earmarking it for a specific school. If half of the doctors in the country would contribute $100.00 a year, this amount plus what will be obtained by the Fund would solve the financial problems of our medical schools and protect their high standards.

Q. Why does not the A.M.A. collect its dues direct, instead of having the County Societies collect them?

A. The A.M.A. has no idea from whom to collect dues. Interns and residents (up to five years after graduation), those in military service, those wholly retired from practice, those over 70 years of age, those who are ill, and those for whom it would be a financial hardship to pay dues are exempt. The County Society is the only agency which can determine some of these factors. There have been many difficulties in working out a smooth running scheme for collecting dues, but they are gradually ironing out. County Societies are urged to forward dues collected promptly, and State Societies also, and not to wait until they have an appreciable sum of money to forward. If they will do this, it will speed up the issuing of membership cards.

Q. Why does the A.M.A. have two classes of membership—Members and Fellows? What is the difference?

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A. To answer this we must go back before 1950. Up until that time whenever a doctor joined his county society, he automatically became a member of his State Society and of the A.M.A. He paid an assessment to his State Society but nothing to the A.M.A. Fellows of the A.M.A. were those members who were elected by the Judicial Council and they paid Fellowship dues which covered only the cost of the A.M.A. scientific publication they elected to receive. Fellows only are eligible for membership in the House of Delegates, as officers, and to take part in the scientific programs of the Association.

Any member could apply for Fellowship and his election was more or less automatic, unless he had something unfavorable in his record in the matter of ethics or involvement with the law, or was a graduate of an un accepted medical school. In the latter case he had to wait a stated term of years before being eligible.

When dues were made mandatory and subscription to the Journal included in the dues, the Fellowship dues were reduced to five dollars. The Fellow still is the only one eligible to take part in scientific programs or to hold office or be a member of the House of Delegates. He also has the choice of receiving either the *Journal* or one of the special journals as part of his membership. There has been considerable discussion recently as to the advisability of having only one class of membership. It will be further considered at the next meeting of the House of Delegates.

Drug Aids in Dislodging Objects Swallowed or Inhaled by Children.

A new use for an old drug—aminophylline—to aid in dislodging foreign bodies swallowed or inhaled by children was reported in the Journal of the American Medical Association, of November 24.

The drug, long prescribed to treat asthma, has been used successfully to relax the bronchial muscles and thus permit spontaneous remission of foreign objects inhaled or swallowed by youngsters, according to Dr. I. Newton Kugelmass, of New York.

Four such cases involving children were described by the doctor, who treated them by rectal retention of the drug. Prompt remission resulted.

"Children inspire or swallow foreign bodies because they explore things with their mouths," Dr. Kugelmass said. "Inspiration of such objects into the air passages is usually the result of a sudden gasp for breath after excitement, crying, or laughing, but swallowing may force an object over the laryngeal aperature [voice organ]."

New Drug Successfully Used to Combat Skin Disorders.

Banthine (trade name) bromide, a new drug, has been successfully used in the treatment of excessive perspiration and certain skin conditions aggravated or produced by it, an article in the Archives of Dermatology and Syphilology, published by the American Medical Association, reported.

"It is our impression that banthine is of definite value in the treatment of certain diseases of the sweat glands," according to Drs. Crawford S. Brown of Boston and I. Lewis Sandler of Washington. Dr. Sandler is assistant professor of dermatology at the Georgetown University School of Medicine.

Twenty-seven persons suffering from excessive perspiration or common skin disorders associated with it were given oral doses of the drug. Observational studies of the results were made for an average of eight weeks.

According to the report, 74 per cent of the patients showed marked improvement, 19 per cent showed moderate improvement, and seven per cent showed slight improvement.

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ANTIHISTAMINICS*

HARVEY B. HAAG, M.D.,
Professor of Pharmacology, Medical College of Virginia,
Richmond, Virginia.

The drugs which have been introduced under the term "Antihistaminics", "Antihistamines", or "histamine-antagonizing agents" are synthetic substances of differing chemical compositions which, while they may have somewhat diverse pharmacological actions otherwise, have the common property of blocking the action of histamine, not, however, destroying it. The rationale of their clinical use is largely based on the premise that in allergic reactions histamine or a histamine-like substance is released and accounts for the various phenomena of the disease condition.

As of the present, there are at least a score of antihistaminic drugs available for general clinical use. This situation has been pictured as reminiscent of a "gold rush" by drug manufacturers "to stake out claims". So as to have some control over this tendency to multiplicity of preparations, it has been suggested that the Council on Pharmacy and Chemistry of the American Medical Association decline to accept further antihistaminic drugs unless they offer at least one of the following advantages over the agents already accepted: (1) that the drug have a greatly increased potency over those now available so that it would be possible to give relief to certain allergic manifestations not relievable now; (2) that the drug be much less toxic than any now available, and not 10 or 20 per cent less toxic; (3) that the drug be more active for a much greater duration, not just three or four hours, but twenty-four hours; (4) that the drug have other than histaminic actions, such as sympathomimetic action; or some other action that in some way interferes with the allergic mechanism.

By and large, it appears at present that all of the commonly used antihistaminics are probably of about equal therapeutic effectiveness in the dosages customarily used. In view of this, it would appear advisable for the physician to become thoroughly familiar with the use of a limited number of these preparations rather than, because of spreading his experience too widely and therefore too thinly, have only a smattering of information concerning a large number.

These compounds inhibit the stimulating action of histamine on certain secretions, such as those of the lacrimal, salivary and bronchial glands. On the other hand, they do not prevent histamine from increasing gastric secretions. They inhibit the dilating effect of histamine on the arterio-venous network and its tendency to increase capillary permeability. Furthermore, experimentally they counteract the constricting effect of histamine on certain smooth muscles, such as those of the bronchial tree. They also prevent the whealing produced by the local application of histamine.

In animals some of the compounds of this group have been found to intensify the pressor action of epinephrine; others have been found to dampen this action. At this point it might be indicated that "epinephrine fastness", as encountered clinically in the use of epinephrine in bronchial asthma, has been related to an action of epinephrine on the adrenal glands resulting in the liberation of histamine, an antagonist to the bronchial dilating action of epinephrine. Because of its inhibiting effect on the action of histamine, antihistaminic therapy has been advocated for the purpose of counteracting this "fastness".

To further illustrate pharmacological differences which might exist between individual antihistaminics: some possess atropine-like effects, some the properties of nitrites (insofar as action on smooth muscle is concerned), some have a quinidine effect, and some inhibit the activity of hyaluronidase.

Practically all of these drugs are locally anesthetic and systemically tend to have a sedative and slightly analgesic effect on the central nervous system. In this latter connection, it has been found that certain antihistaminics tend to potentiate the depressing action of barbiturates, in view of which finding combinations of these drugs with members of the barbiturate group should be used cautiously. In the case of antihistaminics so studied, no synergism was noted on the intensity of effect of alcohol on the cen-

*Prepared for presentation at the annual meeting of the Medical Society of Virginia, Roanoke, October 9-11, 1950.

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tral nervous system.

With most of these drugs, maximum effectiveness is noted in about one hour following oral administration with activity disappearing more or less totally in from 4 to 6 hours. This rapid rate of detoxication and elimination accounts for the finding that they have little or no cumulative effect. The liver seems to be the main organ for detoxifying antihistaminic drugs and hence hepatic disease might influence the extent of their activity.

In rare cases therapy with this group of drugs by intravenous administration might be desirable; for instance, diphenhydramine (Benadryl) can be given by vein in doses varying from 10 to 50 mg. dissolved in about 20 cc. of saline and administered slowly. Some can also be given subcutaneously and intramuscularly.

Many of the antihistaminics are available for local application in ointment form, usually of 2% concentration.

The single oral dose for individual members of this group of drugs for adults varies from 4 mg. to 100 mg. With the exception of the very potent preparations, the usual dose for children is from 4 to 6 mg. per Kg. body weight per day. Most of these preparations as such have a somewhat unpleasant taste, making administration in plain solution, particularly to children, at times difficult. This can be largely circumvented by the use of proper disguising vehicles.

As is to be expected on the basis of chemical differences existing between the various antihistaminics, the intensity of their antihistaminic action has also been found to vary. The comparative antihistaminic activity of a series of these agents can be studied in the laboratory by determining the concentration of the various drugs necessary to antagonize the action of a given concentration of histamine on isolated ileum strips and bronchial rings of guinea pigs. They may also be compared in terms of their relative ability to prevent histaminic poisoning in intact guinea pigs, to which histamine has been administered either by injection or by aerosol inhalation. Sometimes the comparative values determined in the laboratory by these several technics are found to carry over to man, and sometimes not.

In the final analysis, the relative activity and efficiency of any series of drugs intended for human therapeutics must ultimately be determined on man. As is, unfortunately, the case with many other drugs, in the clinical testing and comparing of antihistaminic agents, many of the reported observations represent studies in which adequate control procedures were not employed. To realize the great importance of including control observations in studies aimed at comparing the therapeutic efficiency of various members of the antihistaminic group of drugs, one needs only to note that placebos alone were found to alleviate certain symptoms of allergy in 33% of the cases in one series of patients.

Insofar as they measure the relative antagonistic action of various antihistaminic drugs against one type of histaminic effect, several technics in which histamine is applied locally in humans offer the definite advantage over most other kinds of clinical studies in that psychologic factors are practically eliminated. In one type of such studies histaminic solutions with and without an antihistaminic are applied to the scarified skin and the extent of whealing noted. In another type of observations histamine is administered by iontophoresis into the skin and the effect of an orally administered antihistaminic noted on the extent of whealing. However, even in employing such objective technics as these it is difficult to obtain a clear picture of comparative efficiency. For instance, in one study in which histamine was applied to scarified areas with and without an antihistaminic, it was found that drug 1 was only about 1/3 as effective as drug 2. On the other hand, in a study in which histamine was administered by iontophoresis and the antihistaminic given by mouth, drug 1 and drug 2 had the same activity. Because, as previously stated, antihistaminics exert other actions than purely histamine-antagonizing ones, it could well be that one preparation might achieve a low rating by such tests as these and yet be superior in regard to other actions.

In the clinical use of these drugs it should be borne in mind that they are not curative of the underlying physiological disturbances leading to the production of histamine-like phenomena. Furthermore, it is to be noted that it is in the therapeusis of conditions of the skin and mucous membrane characterized by vascular phenomena that they have proven most successful, particularly if these phenomena are mild. In deeper seated allergic states such as the bronchospasm of asthma and the arthralgia of serum sickness, they are of only occasional

XUM

value. In no type of allergy has any conclusive evidence been obtained that these drugs have any significant effect on the eosinophile picture.

The antihistaminic preparations have their greatest therapuetic effectiveness on nasal allergies; on seasonal hay fever more than on perennial vasomotor rhinitis. In these conditions the congestion of the mucous membranes is reduced as is the rhinitis and pruritus of the nose, eyes, and throat. Likewise benefit is usually derived by the administration of these drugs in the treatment of urticaria, angioneurotic edema, serum sickness (except for the pyrexia and arthralgia), reactions from penicillin and other drugs, itching skin conditions such as atopic dermatitis, pruritus ani and vulvae, allergic food reactions, insect bites and nettle stings. In this connection it is interesting to note that the venom of certain common insects contains histamine, while that from nettles contains both histamine and acetylcholine.

In the treatment of itching skin conditions the drugs are sometimes applied locally in ointment form. Presumably here relief is associated both with their antihistaminic action, and with their local anesthetic effect. This local anesthetic effect alone would tend to promote healing by stopping the scratching induced by itching. It is worth remembering, not only in connection with their local use, but also with their systemic use, that these drugs themselves can produce a dermatitis and occasionally aggravate an already existing dermatitis.

These agents, particularly diphenhydramine (Benadryl) and its theophylline derivative (Dramamine) have been used in the treatment of motion sickness. A recent report indicates that a combination of diphenhydramine (Benadryl) with scopolamine is more effective than either agent alone.

Some reports have indicated the usefulness of these agents in reactions from anti-rabic vaccine, sun burn, sensitivity to cold, transfusion reactions, reactions from injections of liver and insulin, and in bringing relief in instances of bronchospasm due to curare. It may be noted that procaine possesses an antihistaminic effect and in the treatment of curare bronchospasm it has been recommended on the basis of this action.

In spite of the fact that it has been demonstrated rather conclusively that these drugs are generally of little or no value in the treatment of asthma, their use for this purpose still seems to be rather widespread. They might prove beneficial in treating spasmodic bronchial coughing in children.

Thus far their usefulness, other than that due to their sedative and analgesic actions on the central nervous system, in the treatment of radiation sickness, migraine (except spontaneous histaminic cephalgia) Parkinsonism, vomiting of pregnancy, periarteritis nodosa, allergic purpurea, scleroderma, and in the ordinary cold is questionable and remains to be demonstrated.

Attendant upon the release of antihistaminics for over-the-counter sale to the general public, criticism has been leveled at the Food and Drug Administration, and so it may be in order to briefly discuss the position of this agency in such matters. In this case, as in the release of all new drugs, the Food and Drug Administration allowed the new drug applications concerned to become effective only after adequate and expert medical and pharmacological evidence had been submitted to demonstrate that these drugs were safe for use under the conditions proposed. It cannot be denied that undue advertising claims have been made concerning the efficiency of the antihistaminics in the treatment of the common cold. However, the Food and Drug Administration has no legal control over advertising. It does have authority to deal with the labelling of drugs, and it is noteworthy that label claims have been kept moderate, whereas advertising claims have been much less judicious.

Without exception all of the antihistaminic drugs now in general use appear capable of producing undesirable side reactions; the nature, incidence and severity of these toxic actions varying from drug to drug. These side reactions do not appear to be due to an antihistaminic effect. It has been found that patients differ in their sensitivity to the toxic actions of the antihistaminics as a group and also in their response to an individual drug. In view of this an individual may tolerate a preparation which has generally a high index of toxicity better than one which has a lower index.

The commonest side reactions incident to antihistaminic therapy are those referable to effects on the central nervous system. Of these effects sedation is the most frequent, varying in intensity from mild sedation to deep sleep. Associated with the sedative effect there might be dizziness, inability to concen-

trate and disturbed coordination. While in such a state the subject may behave as one under the influence of alcohol. Because of this depressing effect on the central nervous system, initial therapy at least should not be instituted at a time when the patient might be exposed to automobile or occupational hazards. Preferably the initial dose should be given at bed time. In some patients tolerance seems to develop in a matter of several days to the sedative action of the antihistaminic. So as to prevent sedation it has been recommended that either caffeine or amphetamine be used in conjunction with these drugs. Observed less frequently than the sedation is dryness in the mouth, dilated pupils, headache, nervousness, lassitude and, in rare instances, coma or convulsive seizures. It is interesting to note that in experimental animals these compounds in toxic doses almost invariably produce convulsive seizures and in the reported cases of severe poisoning in children a similar reaction has usually been noted.

The antihistaminics are capable of producing typical drug reactions in the skin. In addition, there have been several instances of agranulocytosis and hemolytic anemia found in patients while on antihistaminic therapy. Side effects referable to the gastrointestinal tract also occur; these are minimized by administration of the drugs after meals.

Although serious side reactions are rare, particularly when one considers their widespread use, and the drugs appear to be rapidly detoxified and eliminated, it is advisable that patients under prolonged antihistaminic treatment receive periodic examinations as a preventive measure. There is no specific antidote, treatment being symptomatic.

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XUM

ANEMIA*

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Anemia is defined as a condition of the blood in which there is a deficiency of hemoglobin, in erythrocytes or in the volume of packed erythrocytes per 100 cc.

There have been such radical changes in our concept of the classification and treatment of anemia that it seemed timely to review the subject briefly.

It was not so long ago that a doctor was considered very stupid who required a microscopic examination of a patient's blood to make a diagnosis of anemia and very stubborn if he did not accept the diagnosis of the family or patient and prescribe iron empirically. Certainly the man who was not guided by the miscroscope had fewer worries albeit fewer cures than his more learned successor.

*Read at the annual meeting of The Medical Society of Virginia in Roanoke, October 8-11, 1950.

Then came the day when anemias were simply classified as primary and secondary, those which were not caused by iron deficiency or obvious hemorrhage being primary.

Today the nomenclature in classification is legion, being based on etiology as well as objective findings.

There are now so many subdivisions that it may be more proper to speak of "The Anemias".

The Committee for Clarification of the Nomenclature of Cells and Diseases of the Blood and Blood-forming Organs, sponsored by the American Society of Clinical Pathologists and the American Medical Association,[1] lists the following varieties: Normocytic Anemia, Hypochromic Microcytic Anemia and Macrocytic Anemia.

These are subdivided as follows:

THE ANEMIAS

TERM TO BE USED	TERMS TO BE AVOIDED
NORMOCYTIC ANEMIA, due to	
Unknown cause	
Hypoplastic normocytic anemia (pancytypenia), due to	Refractory anemia, secondary anemia.
Unknown cause	Idiopathic aplastic anemia, panmyelophthisis, aregeneratory anemia, aleukia haemorrhagica, toxic paralytic anemia, cryptogenic anemia, refractory anemia, pancytopenia, Felty's syndrome.
Congenital	Fanconi's syndrome, constitutional infantile anemia.
Poison (specify, as benzol)	
Infection	Simple chronic anemia, secondary anemia.
Radiation, from	
Roentgen rays	
Radioactive substances	
Osteopetrosis	Marble bone disease, Albers-Schönberg disease.
Myelofibrosis	
Congestive splenomegaly, due to	
Unknown cause	Banti's disease, splenic anemia.
Thrombosis of splenic or portal vein	
Liver disease	
Normocytic anemia with erythrocytic hypoplasia due to	
Unknown cause	Pseudoaplastic anemia, refractory anemia, progressive hypocythemia, progressive erythrophthisis.
Congenital	
Endocrine hypofunction	
Hypothyroidism	
Poison	
Infection	

Normocytic anemia with myelophthisis, due to	
Unknown cause	Leuko-erythroblastosis, myelopathic anemia, metastatic anemia.
Osteopetrosis	Osteopathia condensans disseminata, chronic non-leukemic myelosis, Albers-Schönberg disease, marble bone disease.
Myelofibrosis	
Amyloidosis	
Metastatic neoplasm	
Leukemia	
Plasmocytic myeloma	
Normocytic anemia from internal destruction of erythrocytes, due to	
Unknown cause	Hemolytic anemia.
Poison	
Lead	
Infection	
Parasite	
Malaria	
Sensitization to Rh-Hr or other erythrocytic agglutinogens	
Hemolytic disease of the (fetus and) newborn	Erythroblastosis fetalis, erythroleukoblastosis, icterus gravis neonatorum, hydrops fetalis.
Transfusion hemolysis	
Internal hemorrhage	
Hemoglobinuria	
Unknown cause	
Paroxysmal hemoglobinuria	Hemoglobinemia.
Unknown cause	
Nocturnal	Marchiafava-Micheli syndrome.
Cold	"e frigore".
Exertional	March hemoglobinuria.
Allergic	
Favism	
Hemolytic normocytic anemia, acquired due to	
Unknown cause	
Acute	Lederer's anemia, Winckel's disease, acute febrile pleiochromic anemia.
Cold agglutinins	
Sulfonamide sensitivity	
Leukemia, lymphocytic	
Ovarian cyst	
Hemolytic normocytic anemia, hereditary, due to	
Hereditary spherocytosis	Familial hemolytic icterus, acholuric jaundice, congenital hemolytic icterus, hemolytic icteroanemia.
Trait	
Hereditary ovalocytosis	
Trait	
Sicklemia	Sicklanemia, drepanocytic anemia, Dresbach's syndrome, Herrick's anemia.
Trait	
Normocytic anemia, due to	
Acute blood loss	
Metabolic disturbance, from	
Unknown cause	
Lipid histiocytosis	
Protein deficiency	
Vitamin deficiency	
Sprue	

XUM

HYPOCHROMIC MICROCYTIC ANEMIA, due to	Secondary anemia, chlorosis.
Unknown cause	Idiopathic anemia, simple achlorhydric anemia, Witt's anemia, Chronic microcytic anemia, idiopathic hypochromaemia, chronic chlorosis, erythronormoblastic anemia.
Chronic blood loss	
Deficient intake, absorption or metabolism of iron	Secondary anemia, hypoferric anemia, achromic anemia, simple anemia, iron deficiency anemia.
Prematurity	
Hereditary leptocytosis	Cooley's anemia, thalassemia, erythroblastic anemia, Mediterranean anemia, disease or fever, target cell anemia, familial microcytic anemia, hereditary or familial poikilocytosis.
Trait	
With erythrocytosis	
MACROCYTIC ANEMIA, pernicious anemia type, due to	
Unknown cause	Achrestic anemia, idiopathic refractory megaloblastic anemia.
Infantile	Megaloblastic anemia of infancy.
Pernicious anemia	Addisonian anemia, Biermer's disease, primary anemia, macrocytic anemia, megaloblastic anemia.
Pregnancy	"Severe" anemia of pregnancy, primary anemia of pregnancy, hemolytic anemia of pregnancy, macrocytic anemia of pregnancy.
Sprue	
Tropical	Indische Sprue, psilosis, aphthae tropicae, tisis intestinal, Cochin-China diarrhoea.
Nontropical	Idiopathic steatorrhea, Gee-Herter disease.
Nutritional deficiency	Goat's milk anemia, tropical macrocytic anemia.
Celiac disease	
Chronic intestinal obstruction	
Diphyllobothriasis	
Gastrectomy	
Disturbance in continuity of the gastrointestinal tract	
Tuberculous enteritis	
MACROCYTIC ANEMIA, due to	
Unknown cause	Achrestic anemia.
Hypoplasia	
Liver disease	

Certain specific terms are to be avoided, particularly secondary anemia, since all anemias are secondary to some cause whether or not that cause is found.

Iron deficiency is recorded as one of the most frequently encountered clinically manifest deficiency diseases.[2] When encountered in adults the disease is rarely, if ever, of dietary origin and must be regarded as evidence of abnormal blood loss.[3]

Iron deficiency anemia occurs under the following conditions:

1. Infants who failed to receive adequate supply of iron from their mother at birth and who have not had suitable supplements.

2. Women who have yielded excessive amounts of iron to their children, particularly women with multiple pregnancies.

3. Persons who have lost blood. Incidently, it may be mentioned that blood donations should not be made oftener than four or five times a year.

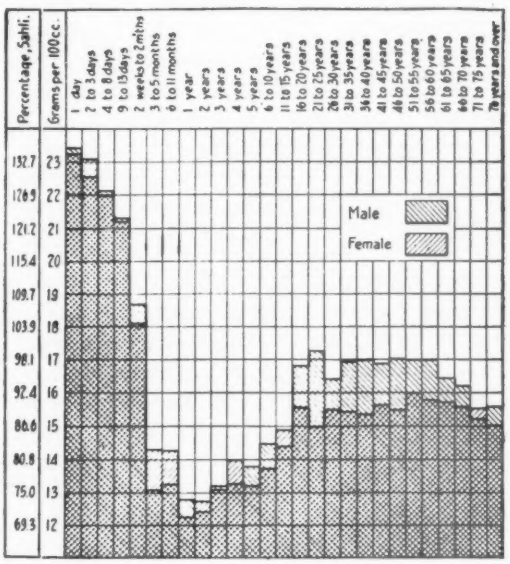
In going over the records of one thousand consecutive office and hospital patients irrespective of symptoms, diagnoses or age, I have found that 13.9% had a hemoglobin content of 12 gm. or less per 100 cc. of blood.

Anemia due to toxic or physical causes (so-called "secondary anemia") may be caused by the following: Chronic infections; parasitic diseases, as malaria, hookworm; prolonged lactation; chronic poisons, as lead, mercury, arsenic, benzol, anilin, nitrobenzol, trinitrotoluol, pyrodin, phenylhydrazine, sedormid, xylene, naphthalene, gold compounds, potassium chlorate, amidopyrene, acetanilid, sulfo-

namides, etc.[4] In these cases the type of anemia may vary without known cause, ranging from many immature red cells to an aplastic form of anemia with decreased number of red cells without young forms.

MACROCYTIC HYPOCHROMIC ANEMIA. Probably the most common cause of this is pernicious anemia but it may occur in pregnancy, pellagra and such gastrointestinal conditions as complete gastrectomy, gastroenterostomy, intestinal short circuit, ulcerative colitis, chronic bacillary and amebic dysentery, idiopathic steatorrhea and certain tape worm infestations.

It is important to bear in mind the fact that the hemoglobin content and red cell count of blood



--Clin. Diag. by Lab. Methods Todd & Sanford - 11th Ed.

Fig. 1.

vary with age and sex. For instance, hemoglobin content in the blood of the one day old infant averages 20 gm. per 100 cc. It falls rapidly, so that by the end of the second month it averages approximately 10.5 gm. per 100 cc. and reaches a low of 9.5 gm. at the age of ten months; after the first year it rises gradually, running higher in the male than in the female, until 60 years of age, when the difference decreases and the hemoglobin content is approximately the same for male and female during the remainder of life. (Fig. 1)

The importance of the soil in relation to the mineral requirements of grazing animals has long been recognized. Acute symptoms of phosphorus, cobalt, iodine and copper deficiencies have thus been identified.[5]

The situation for animals and for man is by no means comparable and it is generally believed that the minerals in soil do not affect the iron content of vegetables sufficiently to cause anemia.

TREATMENT. The treatment of anemia consists of

1. Removal of cause.
2. Replacement of blood by transfusion, if severe.
3. Specific therapeutic measures. Iron is only useful in iron deficiency anemia. Iron therapy if efficacious should be followed by a rise of hemoglobin at a rate of 0.1 to 0.2 gm. per 100 c.m.l. of blood daily.

Liver extract, folic acid and B 12 are essentials in treating pernicious anemia and the allied macrocytic anemias. Transfusions are particularly useful in cases of severe anemia or sudden blood loss.

SUMMARY. Anemia is a symptom of a wide variety of disease conditions and the treatment hinges on the type one is dealing with.

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DISCUSSION

DR. JOHN EDGAR STEVENS, Richmond: I enjoyed Dr. Graves' paper. I would like to emphasize one point that is very common in types of anemia we encounter in private practice which I think Dr. Graves will agree is the most common type, that of iron deficiency. This is the type that commonly occurs in females up to the age of menopause. In patients of this type we try to emphasize the amount of blood lost and therefore the amount of iron lost in the menstrual periods. Previously we have thought the loss of blood during these periods amounted to approximately three ounces; however, more recent work has shown that the amount of blood lost during normal menstrual periods may amount to 250 cc. or as much as 500 cc. each period. This is most important, for we recall if a normal male gave a transfusion of 500 cc. of

whole blood it has been estimated that it takes approximately six to seven weeks for him to regenerate blood back to the normal level that he had prior to the giving of this transfusion.

This analogy is used in trying to explain the hypochromic anemias to these women particularly. They are told that if it takes a man that long to regenerate blood, they can imagine how much iron they have lost month after month.

Unless they eat an adequate diet, or, in most cases, take iron to replenish that which is lost during menstrual periods, usually they will develop an iron deficient anemia. I also try to classify these women as the "secretary type", who are "coke and nab eaters" at lunch time. Certainly their diet is usually an inadequate one. Then added to it, they are not getting enough iron by taking supplementary amounts. Usually they come into the office with certainly a moderate to sometimes severe degree of hypochromic anemia.

I think Dr. Graves' remarks regarding specific treatment are most important because these females will respond and respond very rapidly if intake is sufficient. The main failing is that we give too little iron instead of too much and if we do not get the results we desire we give up on iron and then immediately resort to the so-called shotgun prescription. I think that practice is to be deplored and if it is iron deficiency anemia we should treat it with iron, insisting that the amount they take is sufficient to correct the deficiency. Usually this amount is from 9 to 13 grains per day of the ferrous form.

Severe Bronchial Asthma Reported Eased by Cortisone.

Cortisone administered orally in 12 cases of severe bronchial asthma brought a good therapeutic response in nine patients during the first 24 hours of treatment, two Detroit allergist reported. The results of the administration of the drug in tablet form were related in the August 11 *J.A.M.A.* by Drs. Sidney Friedlaender and Alex S. Friedlaender of the Wayne University College of Medicine. They said that a daily dosage at four to eight hour intervals produced an effect comparable to that obtained with an equivalent amount of the saline suspension of cortisone administered intramuscularly.

"The onset of improvement occurred more rapidly with the oral preparation, sometimes within two to six hours of the initial dose."

As is the experience with the use of cortisone in most cases, a relapse in symptoms occurred in all instances within a few days after cessation of the hormone, the report showed.

"While cortisone administered orally is more convenient and acceptable to the patient, the very ease of administration renders this form of therapy subject to greater abuse," they warned. "Constant supervision and careful observation of the patient is necessary so that one may promptly detect and correct metabolic and hormonal side effects. Another serious factor to be considered in cortisone and adrenocorticotropic hormone (ACTH) therapy is the tendency to precipitate psychic disturbances. Lowered resistance to infection has been shown by recent experiments to occur during cortisone or ACTH therapy.

"In the light of our present limited knowledge regarding the effects of these hormones on immune responses, their use in bronchial asthma should be restricted to those periods of extreme stress when other proved symptomatic measures are ineffective.

"The availability of these hormonal agents does not supplant the necessity for careful examination and immunologic study of each patient with asthma, with the view of determination and control of specific allergic sensitizations, as well as any nonspecific factor that may be contributing to the persistence of symptoms."

XUM

TREATMENT OF INTESTINAL OBSTRUCTION WITH THE AIR-VENT TUBE*

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Since distention is a frequent cause of death in all forms of intestinal obstruction, the efficiency of the tubes available for decompression of the obstructed intestine has long been a matter of concern to us. When suction was applied to one of the usual tubes and the intestine visualized in the autopsy room, the marked demonstration of the mucosa being drawn into the lumen of the tube was amazing. We had been aware that this occurred but had not appreciated just how marked it was before viewing these experiments. It was apparent that this phenomenon, which we have termed the "vacuum mucosa obstruction phenomenon," must be prevented in order to secure adequate removal of the large amounts of fluid present in all cases of obstruction. It was to accomplish this that we designed our air-vent tube† which has been described in detail in an article soon to appear elsewhere.

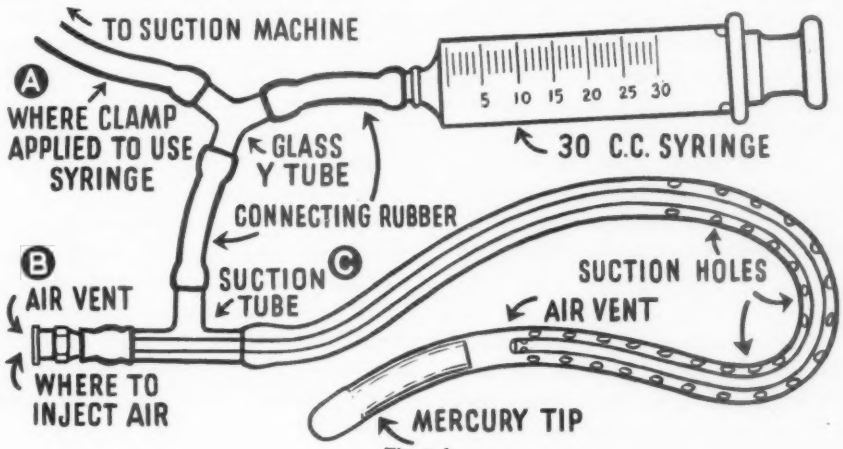

Figure 1.

Figure 1 shows this tube drawn out of proportion in order to visualize all the features of the assembly which we use. The principal feature of the tube is the small plastic inner-tube which is inserted in the outer perforated tube. Instead of pulling the mucosa into the holes of the perforated tube, the suction as it builds up pulls atmospheric air into the intestine through this small air-vent tube—the line of least resistance. Thus the perforations remain clear and free so that a constant suction drainage of fluid and gas becomes possible. We have found no fluid between the pylorus and the ileum that cannot be removed through small holes. Therefore, over a distance of 23 centimeters, we have placed over 100 small holes rather than the customary 6 to 8 large holes. We have also found that passage of the tube through the pylorus and down the intestine is greatly facilitated by weighing the tip with mercury.

Nursing care is reduced to a minimum with the closed system of drainage assembly shown in Figure 1. The nurse can tell at a glance whether or not the apparatus is functioning. If neither gas nor fluid is being removed, she draws back the

*Read at the annual meeting of The Medical Society of Virginia at Virginia Beach, October 7-10, 1951.

†Manufactured by George P. Pilling & Son Company, Philadelphia.

plunger of the 30 cc. syringe; if this does not immediately return to position, she checks the connections to the suction machine. If this fails to reestablish drainage, she can place a clamp on the tube to the suction machine (at A), and inject air or even fluid at the air-vent (B).

In the clinical management of patients undergoing this continuous type of drainage, it is necessary to give careful consideration to the replacement of the huge volumes of fluids removed (sometimes as much as 6,000-10,000 cc. in 24 hours) and the large loss of electrolytes, including sodium, potassium, chloride and bicarbonate. It becomes most important that careful, accurate intake and output records be kept, and that sound knowledge of the fundamental details of water and electrolyte balance govern replacement therapy. As Dr. Evans[1] and his group at the Medical College of Virginia have so frequently emphasized, cation and anion changes following suction drainage can be interpreted quite well by the simpler laboratory tests, provided the proper insight into electrolyte metabolism is available.

This type of drainage may prove to be a valuable research approach to the problem of acute water and salt depletion.

It should be borne in mind that the air-vent tube is to be looked upon as an aid in the treatment of intestinal obstruction and neither it nor any other tube should take the place of good surgical judgment. In our opinion a tube has little place in the treatment of large bowel obstruction; in such cases a cecostomy or colostomy should be performed as soon as possible.

In this paper we wish to describe the treatment of 3 cases of obstruction of the small intestine to illustrate the advantage of the air-vent tube in securing rapid efficient decompression. The experience and results of others are eagerly awaited.

Case 1. The patient was a 32-year-old colored man, admitted September 1, 1951, with abdominal distention of 2 days duration. This man had been drinking heavily for about a month before onset of the present illness. One week before admission he experienced a sudden onset of severe epigastric pain which was soon followed by nausea and vomiting. The pain continued severe and localized in the epigastrium for 2 days and then gradually subsided, but the nausea persisted. About 2 days before admission he noted distention of the abdomen, which became progessively more severe.

On admission the patient complained of only moderate abdominal pain and distention, but he was vomiting and appeared somewhat irrational. The abdomen was moderately distended and showed the contour of distended loops of bowel on the anterior wall. No masses were demonstrated, and there was no localized tenderness. Considerable free fluid could be demonstrated in the abdomen; no bowel sounds were heard. The cul de sac bulged into the rectum.

The diagnosis was generalized peritonitis with paralytic ileus following a perforated duodenal ulcer a week before admission. There was marked dehydration. An air-vent tube was inserted, and intravenous fluids, penicillin, and streptomycin were started. Upright films of the abdomen showed greatly distended loops of the bowel with free fluid in the lower abdomen. In the first 10 hours 3,000 cc. of intravenous fluids were given and 1,200 cc. of gastric contents were aspirated, with considerable improvement in the patient's general condition. On succeeding days the following amounts of fluids were given and aspirated: first day, 3,000 cc. given, 2,500 cc. aspirated; second day, 4,000 cc. given, 7,300 cc. aspirated; third day, 4,000 cc. given, 10,000 cc. aspirated; fourth day, 4,000 cc. given, 9,200 cc. aspirated; fifth day, 3,500 cc. given, 8,300 cc. aspirated; sixth day, 4,000 cc. given, 7,500 aspirated. By the third day the tube was demonstrated to have passed through the duodenum beyond the ligament of Treitz. The patient was much improved, and was permitted to take fluids freely by mouth. On the sixth day faint bowel sounds were heard, and the patient passed a small liquid stool. On the seventh day the patient was quite comfortable, had good bowel sounds and two bowel movements. The tube was removed and the patient made an uneventful recovery.

In this case of functional obstruction, adequate suction drainage contributed to a rapid recovery without surgery.

Case 2. The patient was an 81-year-old colored man admitted to the hospital March 21, 1951, with rather complete, non-strangulating mechanical obstruction of the small bowel. He had sustained a gunshot wound in the abdomen 25 years previously. The presence of congestive heart failure and severe dehydration and electrolyte imbalance made conservative therapy mandatory in the immediate post-

admission period. A Miller-Abbott tube would not pass into the duodenum despite numerous efforts by various technics. Some, but not adequate, decompression was obtained with this tube. A Devine tube was inserted rather easily into the duodenum under fluoroscopic control, and 4,100 cc. of dark brown, malodorous intestinal contents were aspirated in the first 24 hours. For the next 3 days, 3,000 cc. of intestinal fluid was obtained each 24 hours. This fluid gradually assumed a more normal appearance. The patient was given supportive therapy to prepare him for surgery.

Five days after admission a laparotomy was performed. The entire proximal gastrointestinal tract was found to be well decompressed except for some dilatation of the 6 inches of jejunum between the tip of the tube and the site of the obstruction. The proximal jejunum was threaded on the tube. Exposure was easily managed since distention did not interfere technically. The jejunum was found to be adhered to the old, upper abdominal gunshot wound. The offending adhesions were severed by sharp dissection. The twisted jejunal limbs were adherent to each other; these bands were severed, thus entirely freeing the jejunum. In addition, adhesions between a short segment of the transverse colon and the old abdominal wound were also severed.

The postoperative course was complicated by a febrile episode, and during most of the hospital stay, the patient was maintained on gastric tube feeding and intravenous fluids. However, he made a gradual recovery and was ultimately discharged in good health.

This is a case in which the very poor physical condition of the patient made it imperative that prompt and efficient decompression be secured in order that the patient could be carried on conservative therapy until he could be built up sufficiently to tolerate surgery.

Case 3. The patient was a 37-year-old colored female who was admitted February 1, 1951, with findings and symptomatology of acute pelvic inflammatory disease with pelvic abscess.

After treatment with penicillin 100,000 units every 3 hours; streptomycin 250 mgm. every 3 hours and sulfadiazine grams 1 every 4 hours without relief, the patient was taken to the operating room February 8 for pelvic laparotomy and excision of the right tubo-ovarian abscess. A cigarette drain was left in the wound. Postoperatively the patient continued a septic course and developed stony hard tympanitic distention. She was treated with a Levine tube from February 10 to February 12 without exceptional progress. On that date an air-vent tube was inserted plus a Devine rectal suction tube, with prompt, definite results. Gastric drainage of 3,000 cc. was obtained in 6 hours, and the patient had 4 bowel movements within 12 hours. On February 17 the patient was started on intravenous terramycin 500 mgm. every 12 hours. After rapid progress with effective suction and proper chemotherapy the tube was removed February 19. The patient was eating by mouth and able to be out of bed in a chair. Her temperature resolved by lysis. Improvement continued and patient did well for 3 days. On February 22 she again became distended, apparently with true mechanical obstruction rather than adynamic ileus which the postoperative episode was thought to be. Her temperature and white count continued to drop. The Levine tube was reinserted immediately but changed 24 hours later for an air-vent tube with prompt relief of distention. A barium enema on February 26 revealed no abnormality of large bowel. On March 1 progress of tube halted in terminal ileum. A subsequent barium injection, March 2, showed obstruction. The tube was withdrawn slightly and a second x-ray (March 3) showed passage of barium. The tube was clamped and the patient put on feedings by mouth exclusively. On March 4 the tube was removed. During the last 4 hospital days the patient got along well, was out of bed and eating low residue diet with no apparent ill effect.

In this case the air-vent tube was used to overcome a post-operative adynamic ileus, and later to relieve the distention of true mechanical obstruction.

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XUM

THE PRACTICAL MANAGEMENT OF ALOPECIA

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Only too often the general physician and dermatologist feel at a complete loss in the practical approach to the problem of alopecia. To be sure there is a great dearth of knowledge on the subject but with relatively pertinent questioning the etiological factors may be elicited and a logical plan of internal therapy and reasonable external management may be instituted.

First of all, one must remember that alopecia is a serious problem with the patient, no matter what the physician may or may not think of its importance. In some, it has already caused considerable psychic trauma, and others, who do not receive proper consideration, soon find themselves in the hands of the charlatan and advertising trichologist.

Although the classifications of alopecia may not always be clearcut, and at times almost overlapping, one must arrive at some plan of questioning that will lead to a diagnosis of the individual case. Such a line of inquiry may be somewhat as follows:

1. How long has your hair been falling?
2. Over what part of the head does the hair loss seem to be the greatest?
3. How much do you brush your hair?
4. How much hair remains on your comb each time you use it?
5. Is your hair dry or oily?
6. Do you have dandruff, scaliness or itching of the scalp?
7. Do you use a hair pomade, tint, lacquer, shampoo, etc.?
8. Have you had a permanent wave recently?
9. Is your skin dry or oily?
10. What is the condition of your fingernails?
11. Do the nails break off easily?
12. Have you had an infection in your throat, teeth, or otherwise?
13. Have you been ill or had a fever?
14. Have you been taking sulfa or other medicine?
15. Have you been on a diet of late?
16. Have you had a baby recently?
17. Do you get adequate rest?
18. Have you suffered from shock or been under an emotional strain of late?

From this information, plus additional individual questioning, and a general physical examination, one should be able to make a diagnosis. This will enable the physician to classify and study other cases, and give the patient a reasonable explanation for the hair loss and what to do about it. The following classifications are suggested:

1. Premature alopecia
2. Seborrhœic alopecia
3. Toxic alopecia
4. Endocrine alopecia
5. Deficiency alopecia
6. Nervous alopecia
7. Alopecia areata and alopecia totalis
8. Senile alopecia
9. Hereditary alopecia

The physical check-up should be made with a view to bringing out any endocrine or vitamin deficiencies, foci of infection, nervous syndromes, etc. Special attention should be given to the skin, nails, teeth, tongue, and hair distribution.

Laboratory tests such as a urinalysis, basal metabolism, blood sugar, blood cholestrol, microscopic examination of the hair and scalp for fungus, parasites, and other organisms are sometimes of value. A wood light should be available to study the hair for fluorescence.

This article does not propose a discussion of alopecia due to trauma, permanent waves, or x-ray. Neither do we consider it practical to go into the rare congenital or atrophic anomalies of the hair. Alopecia due to ringworm has been adequately discussed in the current literature during the past few years. Folliculitis decalvans and pseudopelade are classical but rare forms of alopecia and better studied in a dermatological text.

In estimating the degree of hair growth expectancy one must bear in mind that the normal rate of hair growth is believed to be less than one-half millimeter per day. The average length of female hair is 65 cm. and for males 10 cm. The life cycle

of the hair is about four years.

Seymour[1], Trotter[2], Danforth[3], and others have studied the effect of factors that modify the degree of hair growth, such as sunlight, shaving, season, temperature, and cutting. These influences are often variable and yet very definite in many cases.

ALOPECIA PREMATURA

In this condition the hair usually begins to fall before the age of twenty-five. The progress is slow and each regrowth of hair is weaker and more sparse than the preceding. The vertex is usually the first area involved, or it may begin in the anterior area associated with a recession at the sides. It may or may not be accompanied by dandruff or seborrhoea.

In such cases the patient is more often a younger person who is overworked or worried. The general health is below par, and every effort should be made to build up the patient with such remedies as crude liver extract, thyroid extract, vitamins, especially vitamin B complex, calcium, and other minerals. If the fingernails are soft and break off, and there is a history of early cavities in the teeth, or excessively perspiring palms, calcium is especially indicated.

Locally, mild doses of ultraviolet, three or four stimulating doses of x-ray, 37½ R units to the front and vertex of the scalp, at two or three week intervals will be beneficial. Frequently small doses of x-ray will check hair fall. Adequate fresh air, exercise, and mental relaxation are in order. Massage and brushing should be moderate in such cases. A relatively soft brush should be used.

A suitable stimulating hair lotion would be as follows:

℞

Tincturae Capsici	drams ii
Tincturae Cantharidi	drams i
Spts. Myrciae q.s. a.d.	oz. iv

Sig:

Apply to scalp with moderate friction each night.

If the scalp is too dry ten to thirty drops of castor oil, olive oil, or cocoanut oil may be added to the above prescription. The oil may also be massaged into the scalp separately with the tips of the fingers.

SEBORRHOEIC ALOPECIA

Whether seborrhoeic alopecia is a form of premature alopecia or the forerunner of senile alopecia is difficult to say, but for purposes of this paper it is a type of baldness which appears in association with premature alopecia or in individuals from thirty to fifty years of age. Its predisposing factors seem much the same as premature alopecia, except that the scalp is much more oily, and apparently favors the growth of such organisms as the Pityrosporon ovale and secondary pyogenic infections.

Electrotherapy, such as ultraviolet and x-ray, as mentioned in alopecia prematura, are essentially the same. Definite improvement should result from such therapy and may be sustained by proper local treatment.

Sulphur in one form or another is beneficial especially around the hairline. Colloidal sulphur cream, with or without one to two per cent salicylic acid, or two to five per cent precipitated sulphur in vanishing cream or cold cream, may be used effectively. The newer ointment bases such as aquaphor, H-B ointment base, B. & W. ointment base, and chlocream (Upjohn) are suitable vehicles. Most of these wash out readily.

In addition to the foregoing applications for the hairline area, a lotion is advised for the remainder of the scalp:

℞

Olei Lavendulae	gtts. viii
Resorcinol Monoacetate	drams i or drams ii
Acidi Salicylici	drams ss
Spts. Vini 85% q.s. a.d.	oz. vi

Sig:

Apply to scalp at bedtime.

At first the hair should be shampooed twice a week preferably with a vegetable oil, alcohol shampoo, namely, tincture of green soap, or one of the many detergents, such as Tersus, Drene, etc. Following is a suitable shampoo formula for oily hair:

℞

Olei Lavendulae	1.3
Sodii Carbonatis	2.0
Soft Soap (U.S.P.)	120.0
Isopropyl Alcohol	48.0
Triethanolamine	7.8
Aqua q.s. a.d.	240.0

Sig:

Use as shampoo.

TOXIC ALOPECIA

This type of alopecia frequently follows a chronic debilitating disorder, or severe illness associated with fever. Foci of infection, exfoliative dermatitis, and reaction to drugs, such as thallium, arsenic, sulfa,

XUM

penicillin, may also enter into the etiology. Not long ago the writer encountered an epidemic of paratyphoid in nurses accompanied by many cases of moderate alopecia.

It is obvious that treating the cause must come first, while local stimulating therapy should be similar to that described under alopecia prematura. In such cases the scalp is frequently very dry and scaly. A cocoanut oil shampoo, such as emulsified cocoanut oil, is recommended. Moderate massaging with lanolin, olive oil, or cocoanut oil is advised.

ENDOCRINE ALOPECIA

Undoubtedly the endocrines play an important role in alopecia. At times they appear to be a very singular factor, and in some cases their effects are quite obvious. In most cases one cannot immediately place a finger on the particular gland at fault, thereby failing to get the proper therapeutic response to individual hormone medication. Patience is especially necessary in thyroid therapy since the therapeutic effects of thyroid medication are frequently not discernible in less than two weeks.

Hypothyroidism as seen in myxedema gives a rather definite picture with thin, dry, sheenless hair, together with the other signs of dry, pallid, lifeless skin, and short, brittle nails.

The average case of so-called hypothyroidism is usually a combination of hypopituitary and hypothyroid function combined. Our best results with thyroid have been seen in young girls from 12 to 16 years of age, and in cases where the endocrines, vitamins, liver, etc., have been used as adjunctive and synergistic therapy. It must also be noted that even hyperthyroidism can cause alopecia.

Much more has been done in the relationship of hair growth in hypo and hyper action of the pituitary, ovaries, and gonads. Whether these glands produce their effect on the hair primarily, or with some secondary action with the thyroid, is beyond the scope of this paper. We believe the thyroid is the gland of greatest importance in the growth of hair. It has been said that the loss of hair in women is often accompanied by signs of masculinity. Many cases of hirsutism have been relieved by removal of the ovaries and adrenal tumors. In the treatment of such cases it would seem that hormone therapy should either not be used at all, or only where a most thorough endocrinological study reveals a true basis for its use.

Local therapy must be aimed at remedies that might stimulate latent hair growth, such as moderate brushing, combing, massage, ultraviolet, and stimulation with high frequency diathermy. A suitable prescription for an oily scalp would be:

℞

Tincturae Capsici	drams	ss
Quinine Hydrochloride	gr.	xv
Spts. Myrciae	oz.	iv

Sig:

Apply to scalp with moderate friction at bedtime.

If the hair is dry, a little lanolin, olive oil, cocoanut oil, or light mineral oil may also be used.

DEFICIENCY ALOPECIA

Various reports in literature indicate the important role vitamins play in alopecia. Alopecia of this type frequently follows in individuals who have been on reducing diets. It is especially noted in those in whom the diet has caused too rapid or too great a weight loss, and has not been properly supplemented with adequate vitamins and minerals.

Vitamins A and B are the more important vitamins in hair development. Vitamin A deficiency causes the hair to be dry and brittle. There is also an atrophy of the sebaceous and sweat glands. In vitamin B deficiencies an alopecia plus premature graying of hair is frequently noted, the lack of calcium pantothenate being the chief cause of the latter. A deficiency in the unsaturated fatty acids, sometimes referred to as vitamin F, may likewise play a role as yet undetermined clinically.

In the category of deficiency alopecia we propose to include that large group of women whose hair falls out rapidly from 30 to 60 days after the termination of pregnancy. It appears even in women who have good prenatal nutrition including vitamin D and calcium. As a rule the hair fall is diffuse, and the loss may be as high as 25 to 50%. The fall is quite alarming, and adequate reassurance must be given the patient as to hair regrowth. In our experience three exposures of superficial x-ray 37½ R units to four areas of the scalp frequently stops this hair fall. We have checked the foregoing with several other dermatologists who concur that x-ray in small doses will check hair loss and stimulate hair regrowth. Other useful remedies include intramuscular injections of crude liver extract—two units to

XUM

the cc.—once or twice a week. Calcium by mouth or better intravenously is also beneficial. Injection therapy is especially preferable where one is working against time to stop the hair loss. It may later be followed by oral therapy.

NERVOUS ALOPECIA

In this group one finds the person who has developed a fixation about his hair loss. Various types of subjective feelings, such as pruritus, pricking, crawling, and burning occur; these are frequently associated with a moderate, gradual hair loss. Occasionally there is secondary infection from scratching. In many cases the problem is the result of nervous shock. It may be a prominent factor in those seeking careers where their appearance is of paramount importance. Deficient protein and carbohydrate metabolism or improper oxidation of fats may enter into the picture. Sedation, calcium, and other minerals, regulation of the environment, adequate rest, and proper psychiatric management are necessary. Local applications with counter-irritants are important. Antipruritic agents and antibiotics, or other antiseptics, may be necessary to combat the secondary infection. Lotions suggested under alopecia prematura and alopecia senilis may be used.

Many times scalp pruritus develops from worry over loss of hair, or some guilt complex of earlier life. Many patients have made up their minds that there is a definite germ causing their pruritus, and that it is necessary to kill this germ before the pruritus will cease. Frequently it is well to agree with them, giving them medicines which will build up their resistance and relieve their nervous apprehension. Dexedrine, intravenous bromides, calcium, and liver may be used. These measures subserve the purpose of restoring faith in the patient's own desire to get well, and at the same time building up the general physical condition which may help to throw off the agonizing mental obsession.

ALOPECIA AREATA AND ALOPECIA TOTALIS

Although it has been the general purpose of this article to deal with the more diffuse types of baldness, we would probably be amiss to overlook this common problem.

Very definitely the nervous system plays an important role in the etiology of alopecia areata. Shock, fright, worry, anxiety, and exhilaration are frequent causative factors. Most physicians are well aware of the sudden loss of hair in spots. Frequently the condition is not noticed until the patient goes to the beautician or barber. Occasionally there is a slight itching. Usually there are but one or two circular areas of complete alopecia ranging in size from two to three cm. This is generally the extent of the hair loss. At the end of the first or second month a regrowth is noticed either at the perimeter or in the center of the lesions. The condition may likewise appear in the beard where it is often quite persistent and more diffuse. We have studied these cases from the standpoint of foci of infection but have been unable to substantiate any relationship. Cases have been reported after having had dental work performed. Whether these cases are the result of the shock and fear that some individuals have of dental procedures, or an interference in the sympathetic relation of the nerves of the scalp and teeth may be open to question. Absolute reassurance is necessary in cases of alopecia areata. Hair regrowth usually does not recur for three to six months. Local therapy is of little avail, but stimulating local remedies may be used, such as applications of phenol followed immediately by alcohol, silver nitrate—10 to 15%, Kromayer light, ultraviolet, and even mild doses of x-ray. Three to six per cent sulphur precipitate and oil of cade in petrolatum may be used. Massaging the areas with lanolin or castor oil is said by some to be beneficial.

Alopecia totalis usually, but not necessarily, develops in early life, varying with areas of incomplete to complete hair loss. It has been our experience that these cases follow a nervous inferiority complex of some type. Proper psychiatric study and guidance may be necessary. Oftentimes a complete change of environment and climate is beneficial. We are aware of the type influenced by pregnancy, i.e., while the patient is pregnant the hair will grow in, only to revert to the total alopecia state following the termination of pregnancy. In all cases of alopecia totalis adequate mental rest is essential.

Very few cases of alopecia areata become alopecia totalis.

Savil[4] has collected numerous theories relative to the various causes of alopecia areata and alopecia totalis. Sabouraud criticized his own findings, and those of others, to the effect that there is always a tendency toward hypothesis and conjecture.

XUM

SENILE ALOPECIA

The exact period of onset of senile alopecia differs in each individual. It is associated with other geriatric traits, such as loss of teeth, drying and wrinkling of the skin, graying of the hair, etc. The hair fall is usually slight, but can be quite sudden. The vertex of the scalp is the first area affected, with the process gradually extending towards the forehead. The hair becomes sparse, dry, and short. The pattern is often similar to that of alopecia prematura. Males are more often affected than females. Some authorities consider alopecia senilis merely a late stage of alopecia prematura. Many women are greatly alarmed at the possibility of total baldness. It is very rare to see marked baldness in women from forty to fifty years of age.

The treatment of this condition appears to be essentially one of good hair hygiene, i.e., washing the scalp every two to four weeks with an oil type shampoo or a detergent when preferable. In all cases massaging the scalp with small amounts of olive oil or liquid petrolatum should supplement the washing. Vitamin therapy either by mouth or by injection gives moderate satisfaction in some cases—not so much in the regrowth of hair, but in the preservation of the already existing suit. When itching is an associated factor a general physical checkup is essential. Superficial x-ray therapy—usually two or three applications of 37 R units—will give symptomatic relief. Calcium gluconate and crude liver extract, as well as the antihistamine drugs may also be helpful.

HEREDITARY ALOPECIA

This accounts for most of the more unusual congenital hair anomalies seen from birth. Rattner[5] has shown that patterning is a physiologic inherent trait. Over-growth of hair and contrasted colors are of the same primate trait, and could account for the so-called patterning in some forms of hereditary and premature alopecia.

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1835 Eye Street N. W.

Floral Eponym

LILIUM GRAYI

ASA GRAY (1810-1888)

This best known of all American botanists has only an insignificant lily named for him. Asa Gray graduated in medicine in 1831 from the Medical College at Fairfield, but never practiced. His interest in botany led to an association with Dr. John Torrey which lasted many years. He became assistant professor of chemistry and botany at the College of Physicians and Surgeons. Later he became curator of the New York Lyceum of Natural History and in 1842 he became Fisher Professor of Natural History at Harvard, a position he held for thirty years. He retired in 1872 but continued his literary work until he was paralized in 1887, nine weeks before his death, January 30, 1888.

ADMINISTRATION OF POTASSIUM TO SURGICAL PATIENTS IN A 150 BED HOSPITAL*

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and
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Much has been written in the past few years about the administration of potassium to surgical patients. Most of this work has eminated from university centers. But does the average surgeon see cases in which potassium administration is indicated? We believe that he does and wish to demonstrate the point by presenting several cases.

The recent stimulus to potassium studies has been found in the popularization of the flame photometer. This is an instrument on which potassium and other electrolyte determinations can be performed rapidly. The flame photometer† is an expensive instrument and requires a highly trained person for its operation and maintenance. Therefore, at the present time it is impractical for use in smaller hospitals. Because of this the surgeon must depend on the history and physical examination, an occasional chemical determination of potassium, and the electrocardiogram, plus certain routine chemical laboratory tests that are available to him, such as chloride determination and carbon dioxide combining power.

Schilling,[1] and his group state that the symptoms of potassium deficiency can be divided into two groups. The first group is characterized by the acute onset of skeletal muscle weakness and may occur in chronic nephritis or diabetic acidosis with dehydration. The second group occurs more slowly in the postoperative period, usually from the fourth to the tenth day. This is characterized by drowsiness, languor, paralytic ileus, anorexia, and weakness.

These symptoms, as you can see, are non-specific and may be associated with other disease entities also. It is relatively rare that a surgeon sees patients exhibiting symptoms of the first group, but we believe the second group of symptoms is not uncommonly seen in the postoperative state.

Up until 10 years ago it was thought that potassium was almost entirely an intracellular ion, and sodium an extra-cellular ion. It was also thought that the cell membrane was impermeable to these ions and that there was very little transfer of them across the cell membrane. According to Marks,[2] Evans,[3] and others, in the past decade potassium has been shown to move out of the cell in glycolysis, hemorrhage, shock, dehydration, alkalosis, and whenever the excretion of potassium is greater than the intake. The last, of course, is of prime importance when one is dealing with surgical patients.

Surgical patients are often maintained on parenteral fluids deficient in potassium for long periods of time. It has been repeatedly shown that excretion of potassium by the kidneys continues in spite of a deficient intake. This, of necessity, produces a depletion of the body potassium. Also, many surgical patients have prolonged vomiting or Wangensteen suction or fistulous openings with loss of potassium-containing secretions. It has been thought by some that the excretion of potassium postoperatively may be accelerated as a part of the injury reaction.

Elman[4] found that on six patients having cholecystectomies there was a gradual fall in the amount of sodium and chloride excreted, thus showing an efficient conserving mechanism for these ions in the absence of any intake. On the other hand, potassium and phosphate tended to be excreted at a uniform rate in the first 24-hour period and in some cases there was a greater output during the second 24-hour period than the first. In spite of this, the 96-hour cumulative loss was fairly small; for potassium it was 81 ME. The loss was accompanied by no significant changes in the blood levels of these electrolytes. Elman's conclusion was that in present day parenteral alimentation the routine replacement of potassium is probably indicated on the basis of the fact that loss of this element should be replaced. He admits, though, for short periods of time it is unlikely that small deficits of this electrolyte will cause any serious physiological impairment.

Evan's[3] work confirms Lockwood's[5] conclusion that if gastric suction is continued beyond four to five

*Read at the annual meeting of The Medical Society of Virginia at Virginia Beach, October 7-10, 1951.
From Jefferson Hospital, Roanoke, Virginia.
†Less expensive and more fool-proof flame photometers are becoming increasingly available and this may answer the problem for the smaller hospitals in the not too distant future.

XUM

days, provision should be made for the intravenous administration of adequate doses of potassium salts.

Darrow, Lockwood,[5] Evans,[3] Marks,[2] and others have all described a form of hypochloremic alkalosis that is refractory to saline administration. It has been found in most of these patients that there is a deficiency of body potassium. Darrow, in a recent personal communication, states: "I don't believe we have an explanation of how or why a loss of intracellular potassium leads to a loss of chloride and alkalosis nor how or why chloride deficit with alkalosis leads to a loss of potassium from the cells. It could be a change in renal excretion or membrane equilibrium. However, I am inclined to believe it is renal with perhaps some change at the membranes. We and others are studying the problem which is very complex for it involves the complex interrelationships of renal excretion of electrolyte. Perhaps in a few years we shall at least be able to describe what happens. Certainly, we shall know what conditions lead to acid urine in the presence of alkalosis and what renal loads lead to loss of potassium."

Sedgewick[6] has called attention to the fact that the serum potassium levels are not necessarily an index of intracellular potassium. Evans[3] states that "potassium deficiency can exist in the presence of normal plasma potassium levels" and goes on to suggest that since equipment is not generally available to the average surgeon for these analyses, the surgeon should suspect potassium deficiency whenever there is an uncorrected alkalosis after adequate water and sodium chloride therapy.

Darrow[7] states that 3.5 ME per kilogram in 24 hours is a safe dose. He recommends that it be given by slow drip in not less than 4 hours and preferably in 8 hours or longer. Hypodermoclysis is used almost exclusively for parenteral administration because he believes it is safer. Marks[2] states that the largest dose of parenteral potassium that he has administered was 10 gms. given by clysis over a period of 8 hours. He recommends that when large doses are indicated they be given by mouth if possible. The main precaution to be observed, according to him, is the maintenance of an adequate urinary output. He insists on a daily urinary output of over 750 cc.

Martin[8] states that in serious chronic deficits he gives 10 to 20 gms. of potassium chloride intravenously over a period of 24 hours, or 10 gms. intravenously and 10 gms. orally if the oral route can be used.

We would like to present three cases that we have recently seen at Jefferson Hospital in which we believe potassium played an important part in their course.

Case 1. C.A.B., Hospital No. 92340: The first case is that of a three year old white child admitted to Jefferson Hospital on January 4, 1951, with a three-day history of nausea, vomiting, and abdominal pain. At the time of admission she appeared acutely ill. Her temperature was 101 and pulse rate 120. The physical examination was negative except for the abdomen and this revealed generalized tenderness and spasm over the entire abdomen, but more marked in the right lower quadrant. Her white count was 15,400. The impression was acute appendicitis with possible perforation and peritonitis.

She was operated on shortly after admission. On opening the peritoneal cavity a large quantity of pus was found. The appendix was gangrenous and perforated. An appendectomy was performed and streptomycin and penicillin were placed in the peritoneal cavity. A subfascial drain was inserted. Postoperatively the patient was given both streptomycin and penicillin in adequate doses and aureomycin rectally. The first day of hospitalization she was given 500 cc. of 5% glucose in normal saline and 500 cc. of 5% glucose in water. She was placed on liquids by mouth, but vomited all that she ingested. The following morning she was given 500 cc. of 5% glucose in water by hypodermoclysis. She continued to vomit. Her pulse was rapid and weak and she was semi-stuporous. Her blood chlorides that day were 65.5 ME (normal 77-86 ME). Her CO_2 was reported as 38 volumes per cent or 16.5 ME (normal 23-31 ME).

After obtaining these laboratory reports, she was given 500 cc. of 5% glucose in normal saline as well as 500 cc. of sixth molar sodium lactate. The abdomen at this time was distended.

On January 6, her second postoperative day, she was restless, but sleeping at intervals. Her CO_2 combining power that day was reported as 66 volumes per cent, or 28.7 ME. The chlorides were 67.2 ME. Potassium on that day was 4.55 ME (normal 4.6-5.4). She was given 500 cc. of 5% glucose in normal saline and 500 cc. of 5% glucose

in water that day.

On January 7, her abdomen was still distended. She continued to vomit and she remained semi-stuporous. A Levine tube was inserted and Wangenstein suction was started. She was given 800 cc. of 5% glucose in normal saline and 200 cc. of blood that morning. Her CO_2 combining power that morning was reported as 75.9 volumes per cent, or 33 ME, and her chlorides were 67 ME. In spite of the fact that her serum potassium had been at almost normal levels the preceding day it was felt that she had a potassium deficiency as evidenced by her chlorides and CO_2 combining power and her clinical condition. Therefore, she was given 30 ME of potassium chloride in 500 cc. of normal saline. This fluid was given subcutaneously and over a period of approximately 6 hours. Before the infusion was completed it was noted that there was a rather marked change for the better. Five hours after completion of the fluids it was noted that she expelled a large amount of flatus spontaneously. The next morning when the attending surgeon came on the floor the child was asking for food and was playing with toys. The duodenal tube was removed and she was started on small amounts of soft food and fluids. After that no further intravenous feedings were necessary. Her potassium January 8th was 4.7 ME; chlorides 67.2 ME; CO_2 56 volumes per cent, or 24 ME.

On January 10th her CO_2 combining power was reported at 26 ME (normal 23-31) and her chlorides were 69 ME (normal 77-86). She was discharged well on January 16th.

Case 2. Mr. I.G.H., Hospital No. 92786: This 28 year old man was admitted February 8, 1951. For the past five to six years, he had been having burning epigastric distress, relieved by food and soda. Also there had been intermittent episodes of nausea and vomiting, and, since July, 1950, he had vomited almost every day. For the entire month before admission he had been on a liquid diet, and any solid foods ingested would induce vomiting almost immediately. The patient had lost 35 to 40 pounds in the six months before admission. Gastro-intestinal series at another hospital had revealed a complete pyloric obstruction.

Physical examination revealed an emaciated young man who was acutely dehydrated; otherwise, the examination was negative. His laboratory data on admission showed a white count of 8,250 and homoglobin of 15.0 gms. Blood potassium the day after admission was reported as 3.75 ME (normal 4.6-5.4). Blood chlorides on February 10, 1951, or one day later, were reported as 65.5 ME (normal 77-86 ME), the CO_2 combining power was 68 volumes per cent, or 29.5 ME (normal 23-31 ME), and the total proteins were 7.6. Urinalysis and serology were negative.

The patient was prepared for surgery in the usual manner. He was given blood, amino acids, vitamins, and placed on gastric suction. In addition to this, he was given the following quantities of potassium chloride mixed in with his intravenous fluids for the day and administered slowly. On the 9th of February he was given 60 ME; February 10th, 80 ME; February 11th, 80 ME; February 12, 40 ME. On this date a subtotal gastric resection was performed. Potassium level that day was 3.55 ME. On February 13th, blood chlorides were 60.3 ME, CO_2 combining power was 88 volumes per cent, or 38.2 ME. That day 80 ME of potassium were given. This same amount was given on the 14th and 15th of February. On the 15th the potassium was 5.6 ME. The chlorides were 70.7 ME. On February 20, 1951, his 8th postoperative day, the CO_2 was 58 volumes per cent, or 25.2 ME. The potassium was 5.6 ME.

Pre and postoperatively this man was given a total of 500 ME, or 37.25 gms. of potassium chloride administered over a 7 day period of time.

The patient's postoperative course was uneventful. It is difficult to evaluate exactly what part potassium played in preparing this patient for surgery, since all other agents were utilized also. It was the clinical impression of those who saw the patient that his lethargy improved after administration of potassium, but it may well have been that correction of his dehydration played the larger part. Certainly in the preoperative preparation of a patient, we attempt to bring his entire chemical balance and his nutrition to as near normal as possible.

Case 3. Mrs. L.R.H., Hospital No. 84173: This 47 year old woman was admitted to the Jefferson Hospital March 3, 1951, with a complaint of cramping pains in the lower abdomen of 18 months' duration. These symptoms had started about two months following a supravaginal hysterectomy for myomata uteri and had been progressively more severe. Dur-

ing the six months prior to admission she had had almost constant abdominal pain which had become increasingly severe and had required daily narcotics for relief of pain. Increasing dosages of narcotics had been taken, and it was thought by the referring physician that the patient was an addict at the time of admission.

Physical examination revealed moderate abdominal distention with intestinal patterns easily visible and marked voluntary muscle spasm throughout the lower abdomen. No definite mass was found on abdominal examination. On pelvic examinations, however, a hard, fixed, firm mass was found which had replaced the cervix and was extending slightly into the broad ligaments and superiorly into the floor of the bladder. Sigmoidoscopic and X-ray examinations were not satisfactory due to poor cooperation of the patient, but there was evidence of a partial obstruction in the sigmoid with marked dilatation of the small intestine. She was placed on sulfathaladine by mouth as preparation for colon resection and two days before operation on streptomycin.

On March 9, 1951, the pelvis was explored. A hard carcinoma of the cervix was found which had invaded the urinary bladder and there was direct extension to the mid portion of the sigmoid which was attached in this area and also one loop of ileum which was almost completely obstructed. The ileum and sigmoid were each resected. The left ureter was tremendously dilated and both the left and right ureters went into the mass. It was necessary to transplant both ureters into the rectosigmoid below the sigmoid anastomosis. The lower 2-inches of each ureter was then removed along with the bladder, cervix, and what remained of the round and broad ligaments and pelvic peritoneum. No evidence of remaining malignancy was present grossly.

Postoperatively the patient's course was relatively satisfactory except she appeared constantly weak and lethargic. On the sixth postoperative day potassium level was 3.44 ME. The following day she was started on oral potassium chloride 10 grains twice a day which was continued. On the 11th postoperative day the potassium level was 3.6 ME. The potassium by mouth was increased on that day to 10 grains three times a day. On the following day the patent appeared to be much brighter for the first time and was interested in getting well and increasing her activities. On the 13th postoperative day the potassium level was 6.1 ME. The potassium was then discontinued and the patient's remaining hospital course uneventful. It was the impression of the physicians in charge that there was a definite correlation between the potassium level in this patient and her mental outlook and amount of muscular activity performed.

SUMMARY

The routine postoperative administration of potassium to surgical patients is probably not indicated, but in certain selected cases its use can greatly affect the eventual outcome. We have presented three cases in which we feel that its administration was definitely of value.

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GERIATRICS UNLIMITED*

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The word "geriatrics" was coined in 1909 by the late Dr. Ignatz Nascher, of New York City, to denote a branch of medicine devoted to the diagnosis and treatment of disease in the aged. It is derived from two Greek words meaning "old age" and "relating to a physician." Geriatrics is really a subdivision of a broader field of knowledge, gerontology, which is a study of all the varied divisions of the biological, physical, and social sciences pertaining to age or aging of animal life from amœba to man. This includes aspects of biology, embryology, pediatrics, geriatrics, economics, statistical research, education, and even history. It is indeed a broad field as it encompasses man's whole process of development from the embryo to senility. Now, perhaps, it will be obvious why I have employed the adjective "unlimited" in the title of this paper.

"The days of our years are threescore years and ten and if by reason of strength they be fourscore years, yet is their strength labour and sorrow; for it is soon cut off, and we fly away." So said the psalmist thousands of years ago and so is the problem with us today.

The inception of my own interest in geriatrics was accidental. I was reared in St. Petersburg, Florida, the geriatrics capital of the country and probably of the world. Here the fortunate aged in ideal climatic surroundings have an opportunity of passing their declining years in pleasant companionable retirement of the resort type. That this is but a small part of geriatric management will later be apparent. Secondly, my parents taught me to respect gray hair for its own sake. I have not found this rule of conduct without its delusions, but these have been few and on the whole it seems a good one. Thirdly, the practice of internal medicine is by necessity among increasing numbers of old people. More recently the Health Division of the Richmond Community Council has set up a Committee on Geriatrics of which I am a member and the current chairman. Some of you, particularly the younger members, will observe that I too am growing old.

Historically, interest in the problems of the aged is not new. The hieroglyphic for old age, found on inscriptions dating back to 2700 B.C., is the figure of a bent old man with wasted muscles bowing on a staff. In an Egyptian wisdom book of 1580 B.C., "The Precepts of Ptah-Hotep," is a passage which reads, "To be old is evil for people in every respect." Hippocrates, called the father of medicine, who by the way lived to be 104, wrote about the frequency of catarrh in the aged. The Spartans were governed by a council, the Gerontes, made up of men over 60 years of age. Roger Bacon in the thirteenth century wrote of age. In 1724 Floyer published the work on the treatment of the diseases of the aged, "Medinica Gerocomica." Incidentally, he was the first physician to count the pulse by using a watch and the first to prescribe mineral oil, a drug today still helpful to the aged. In 1849 Day wrote on "Diseases of Advanced Life." Not until 1941 was the American Geriatrics Society founded. Its bi-monthly journal is called *Geriatrics*. The Gerontology Society was founded in 1945 and publishes *The Journal of Gerontology*.

Now what is the factor which has brought about this recent impetus to the importance of geriatrics? The answer is relatively simple though its implications are complex and at the same time quite perplexing. It is that the civilized population as we know it has steadily grown older, and, furthermore, there is reason to believe that it will continue to grow older. For example, the French naturalist, Buffon, observed that in the animal kingdom the duration of life exceeds its growth by a factor between five and seven. Thus, for man this would give him a life expectancy somewhere between 105 and 150 years. Other members of the animal kingdom, for example, the sheep, dog, and horse, normally attain this optimum but man has not as yet. Man's death rate at the age of ten is only one in 1,450, and if this rate could be projected he might live to be

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550. However, I must not go too far afield in the romance of statistics.

In Greece during the Iron and Bronze Ages life expectancy was 18 years, and some 2,000 years ago it was 22 years. In England in the Middle Ages it was 35, and by 1850 this had increased to 40.9 years. (Fig. 1). In the United States as a whole

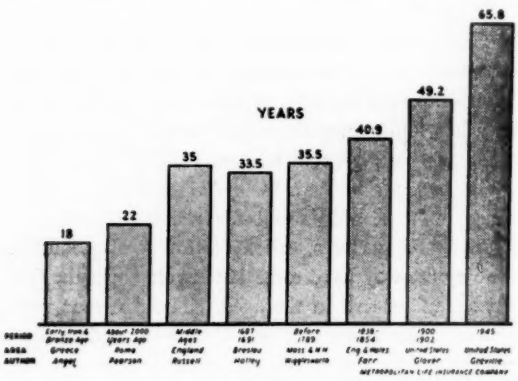

Fig. 1. (Courtesy of Edward J. Stieglitz, Geriatric Medicine, W. B. Saunders Co.)

in 1900 it was 47 years; by 1930 it had jumped to 60; and today it is somewhere between 67 and 69, being two years longer for females than for males. (Fig 2).

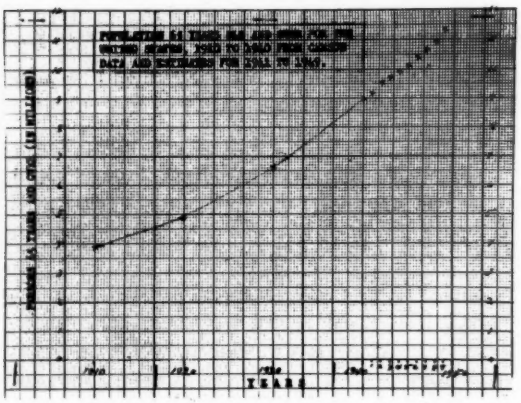

Fig. 2.

That civilization makes the difference rather than centuries is illustrated by the fact that the best records for longevity today are made by English speaking and Scandinavian countries. Ten years ago New Zealand had a life expectancy of 67 years as compared with 62 in the United States. In Mexico life expectancy in 1930 was 33.3 years. The poorest records are found in Asia and Africa. India in 1931 had an expectation of life of slightly less than 27 years, not much better than that of Rome 2,000 years ago. In Egypt in 1936-'38 the life expectancy was 38.6 years or 24 years less than our own average.

Here in Virginia the statistics are equally startling. In 1880 there were 55,800 people 65 years of age and older. (Fig. 3). In 1940 there were

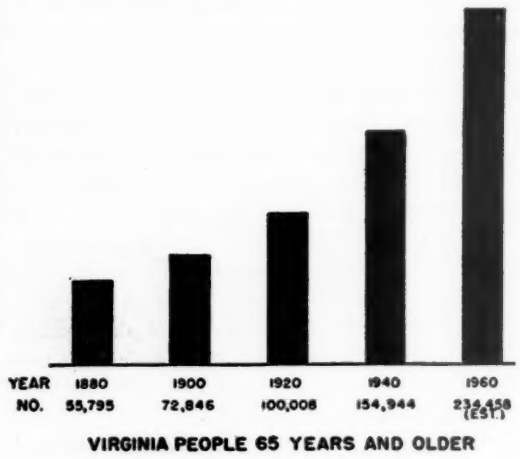

Fig. 3.

155,000. Today there are about 190,000. Stated in a different way, 3.6 per cent of Virginia's population was 65 or older in 1880; 5.8 per cent in 1940; and this will increase to an estimated 6.9 per cent in 1960, with the national figure being about 8.2 per cent.

In the ten years between 1930 and 1940 the total United States population increased 7.2 per cent while those over 65 increased 35 per cent. By 1949 there was a further increase of 21 per cent when the total United States population over 65 was 11,270,000.

In Richmond in 1940 the population over 65 was 11,450, and last year it was 13,288, an increase of 16.1 per cent in nine years, whereas the total population increased only 5.8 per cent. What are the factors which have brought about this almost sudden increase of life expectancy from 47 years at the turn of the century to over 67 years, a 20 year increase in the last 50 years, more than all of the increases since the Middle Ages?

As a physician and a member of the American Medical Association, I am justly proud that this increase has been due in a large measure to the work

of physicians and allied scientists working under a free enterprise system of government. This to me is the strongest argument against regimenting a profession which has given the world its best health and longest living. Let me hasten to add that we physicians are the first to agree that medical care can be improved, but the burden of proof rests with those who say that working under any other system would produce equal if not better results. But let us not lose our golden thread of geriatrics which is the fruition of our efforts and for the moment the theme of this paper.

In the first place, the falling of the birth rate by one-third in the first forty years of this century has diminished the number of young people in this country. Secondly, the almost complete cessation of immigration, which formerly added large numbers of young people, has had a similar effect. Thirdly, we have conquered to a major degree the infectious diseases. For pneumonia, the second cause of all deaths in 1900, we have specific remedies in the sulfonamides and antibiotics. Likewise, these drugs are efficacious in a wide spectrum of infectious diseases due both to bacteria as meningitis, typhoid, erysipelas, and to rickettsiae and viruses as Rocky Mountain spotted fever and typhus; and even tuberculosis for which we do not yet possess a specific remedy, has dropped from first place as a killer in 1900 to seventh place in 1946, or from 195 to 36 per 100,000 persons. Improvements of prenatal and postpartum care have added immeasurably to the chances a child has in life because he or she is well born.

Similarly in the field of pediatrics great strides in nutrition and immunization have strikingly reduced infant and child deaths from diarrhea, diphtheria, and marasmus almost to the vanishing point.

Again, you and I are seldom aware of the public health safeguards constantly thrown about us which add immeasurably to our years. I refer to water purification, milk pasteurization, inspection of public eating places, modern sewage disposal, inspection of meats and other foods not only for bacterial contamination but for quality and adulteration. You and I are not afraid to eat or drink in places approved by our health authorities. Few other world citizens can make this statement.

The first five killers in 1900 were tuberculosis, pneumonia, diarrhea, heart disease, and nephritis. Cancer was eighth. In 1946 the first five were heart disease, cancer, violence, cerebral hemorrhage, and nephritis. Tuberculosis is now seventh. The deaths from heart disease in 1900 were 137 per 100,000 persons; in 1946 were 307 per 100,000 persons. Thus the infectious diseases which killed young and old alike have been largely conquered leaving an increasing number of people to die at an older age of what we refer to as the degenerative or, if you please, geriatric diseases.

The Metropolitan Life Insurance Company has analyzed its causes of death and discovered that 53.1 per cent of deaths in 1901 were due to the so-called chronic diseases. In 1945 this figure had increased to 81.6 per cent, a 28 per cent increase in 44 years.

Mortality statistics, while impressive, do not give us the total picture of what increased longevity means to our social and economic order. Of 3,000,000 people studied in 1935-'36, nervous and mental disorders invalided 269,000 persons; circulatory disorders 205,000; joint diseases 147,000; and so on. While we have more people living longer, we have geometrically increased the number who because of their longevity have fallen prey to incapacitating impairment of their health. The medical profession has done a good job, but by doing so has upset a fundamental balance of nature for which serious counter measures are now in order. Dr. Edward L. Bortz, past president of the American Medical Association, has aptly stated, "The society which fosters research to save human lives cannot escape the responsibility for life thus extended. It is for science not only to add years to life but, more important, to add life to years."

It is estimated that by 1980 one in ten will be over 65 years of age. Of the estimated total population of that year, 60,000,000 will be too young for productive work 20,000,000 will be by present standards too old to work. This leaves a working population of 80,000,000, half of which will be housewives and homekeepers leaving 40,000,000 productive workers to carry the burden of supporting 160,000,000 people. This seems preposterous and therefore almost untenable. Society then must do something about it for survival.

From the medical point of view geriatrics should not be considered a separate medical specialty, but rather an attitude toward the management of the aged. It is not proposed to set up specialized clinics

XUM

for the management of the diseases of the aged, nor to train geriatricians who limit their practice to those 65 and older. Dr. Stieglitz and other experts in this field have warned against this approach.

However, there are special problems to be considered by every physician who deals with older people. The diseases which commonly invalid older people can be grouped under four headings: (1) circulatory disorders which include arteriosclerosis, hypertension, and their special effects on the brain, heart, kidneys, and extremities; (2) metabolic disorders, such as diabetes, anemia, climacteric and gout; (3) malignant tumors; and finally (4) the arthritides. The older patient may have one or usually several of these disorders, and because of their gradual onset be unaware that he is becoming ill. Their progression is certain and spontaneous. Remission rarely if ever recurs. Hence, early recognition is imperative, and prompt treatment for alleviation, if not cure, should be instituted. Acute disease is far more serious in the presence of chronic degenerative processes which, unfortunately, not infrequently serve to mask it.

Reaction to injury is less vigorous, and resistance to infection less effective. Nutrition presents a separate problem. The gastro-intestinal tract of the elderly is less efficient as an absorbing organ. Though the intake may seem adequate, assimilation is often faulty. Hence, vitamin and mineral requirements are greater in order to compensate for decreased utilization.

The elderly man or woman has developed life long habits including proper or improper use of laxatives. The wise physician does not try to make sudden changes in these habit patterns although they seem to violate sound physiological teaching.

Certain drugs are poorly tolerated by the aged. An average dose of morphine may cause respiration to cease as the metabolic fires are low. Bromides may cause psychosis as do the barbiturate sedatives in some. Tolerance for alcohol on the other hand may actually be increased. The aged tolerate operative procedures extremely well if the scope of the surgery is not too broad and radical.

Psychiatrically the aged have at times very complicated problems reaching back over many years. Patience and forbearance are essential in handling not only these but all geriatric problems. The aged patient does not wish to be hurried, nor does he desire to be treated as a child, nor have his doctor casually blame his symptoms on old age and pass it off as this. It is this attitude of patience and understanding which embodies the geriatric approach.

We now have the problem squarely before us. What are the measures which we have begun to evolve for its solution? As you will see, it is not primarily a medical problem, but more a socio-economic one.

We are living in an era which makes man feel that he can and ought to solve all problems from Alaska to Ethiopia and from the Kremlin to Korea, but there are those who are beginning to believe that man may be getting "too big for his breeches" in trying to take on the solution of problems, which are perhaps too big for him, and which had better be left to the good Lord using man in His own time and His own way. Because man has eaten of the apple of atomic energy, he is emboldened to prowl through the cosmic Eden as innocently as little Red Riding Hood and as boldly as Don Quixote, and I am afraid with as disastrous or as useless results, unless perhaps he not too belatedly recalls that he is mortal and not on the Almighty's Board of Directors. So, far be it for me or any other mortal to offer any satisfactory solution to the problems of geriatrics. However, I do not believe we should calmly fold our hands and leave Providence to solve our difficult problems. Progress has never been made this way. Therefore, it would be appropriate to outline first some of the steps which have been taken in Virginia, and then nationally.

From Robert H. Kirkwood's "Fit Surroundings," which, by the way, is a most readable pamphlet on the history of the care of the aged and poor in Virginia, we find our first efforts were patterned after the Elizabethian Poor Laws of 1601. In 1619 the London Company charter gave the governor of Virginia authority to provide for the relief of the destitute. In 1646 the Virginia Assembly passed its first act pertaining to the workhouse. This was passed under the guise of providing for poor children, but really came as a result of English economic interests in setting up the flax industry in Virginia with the cheapest labor. So far as can be determined, no such workhouses were ever built under the terms of the act.

In 1755 an act for employing and better maintaining the poor was passed. The law authorized the vestry of each parish to erect, purchase, or hire buildings to house the people dependent on church

XUM

wards for relief. In 1785 the care of the poor was removed from the vestry and made a responsibility of the state by setting up almshouses under the direction of a superintendent of the poor who was responsible to the county board of supervisors. In 1910 there were 109 alms houses in Virginia, and in 1947 the number was reduced to 22, thirteen in counties and nine in cities.

In 1769 the Eastern State Hospital was established, the first state hospital for the insane in America, and the first for the negro insane. The first school for the deaf and blind in America was established in Staunton soon after 1887.

In 1918 the first district home legislation was passed, and the first home was established in Manassas in 1927, in Waynesboro and Dublin in 1928, and in Chatham in 1929. The district home provides for cooperating counties to pool their resources for a more economical solution of the indigent aged. The total number cared for in 1948 was 264, of which 55 were bedridden, 85 were served meals in their rooms, and 220 or 79.2 per cent were over 65 years of age. In April of 1949 there were 189,278 persons 65 years of age and over, of whom 17,605 or 94 out of every 1,000 were recipients of old age assistance. At that time $37.75 was estimated to provide minimal essentials for adequate physical maintenance. Of this, subtracting income from other than state sources, the average old-age-assistance case cost the state $24.32 per month. Richmond in July of 1950 was caring for 674, or 5 per cent of her population over 65, in approved geriatric facilities.

Louisiana financially aids 834 of every 1,000 persons 65 years of age and older; Georgia, 546; Texas, 506 (Fig. 4). Shades of Huey Long, Gene Talmadge, and Pappy O'Daniel! Virginia's 94 of 1,000 looks pitifully or gratifyingly small depending on your social philosophy. I would like to think that we Virginians take better private interest in our old people and thus have a substantially less burden on the state. Fortunately, the problem of what to do with the aging population is not a problem that the state has to decide by itself. Nationally, of 100 persons past 65 years of age, 34 are still working, 18 live on income and pensions, 17 get private assistance from families or relatives, 9 live on income from investments, and only 22 get public assistance. Thus 78 per cent of the people in the nation pass the age

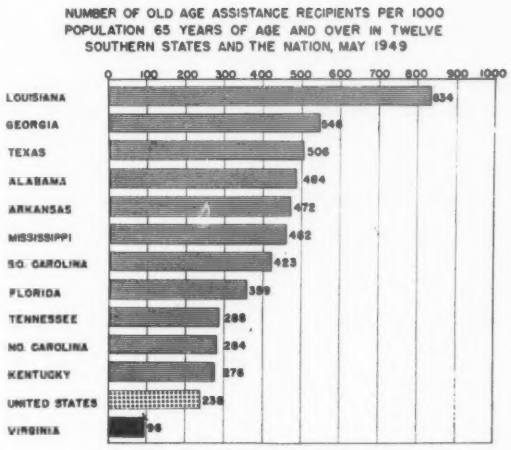
NUMBER OF OLD AGE ASSISTANCE RECIPIENTS PER 1000 POPULATION 65 YEARS OF AGE AND OVER IN TWELVE SOUTHERN STATES AND THE NATION, MAY 1949
0 100 200 300 400 500 600 700 800 900 1000
LOUISIANA 834
GEORGIA 546
TEXAS 506
ALABAMA 484
ARKANSAS 472
MISSISSIPPI 462
SO. CAROLINA 423
FLORIDA 339
TENNESSEE 288
NO. CAROLINA 284
KENTUCKY 276
UNITED STATES 238
VIRGINIA 94

Fig. 4.

of 65 can and do look after their own retirement, and if the state leaves them alone they can probably do a better job.

I recently attended in Washington a conference on aging under the auspices of the Federal Security Administration. Over 800 delegates from all over the country convened for three days to study the various aspects of gerontology. There were about nine major sections each charged with a particular aspect of the problem. These nine sections were divided into 28 sub-committees, and reports were made on research, population changes, employment, income maintenance, health maintenance, rehabilitation, education, family life, housing, recreation, religious, services, community organizations, and the recruitment and training of professional personnel with reference to the needs of older persons. There were doctors, educators, industrialists, labor leaders, clergymen, insurance experts, social workers, and, of course, government representatives. At the closing session of each section a resolution was handed down from the Federal Security Administration proposing that this be called the first conference on aging and that the Federal Security Administration be requested to allot money and to explore further the field of gerontology. Dr. Stieglitz, one of the country's pioneer geriatricians, arose to remind one session that there had been a committee on gerontology and geriatrics in the United States Public Health Service for ten years and recommended that the resolution be tabled. It never reached the final assembly for action, and Mr. Oscar Ewing spent about 15 minutes of his closing remarks

XUM

reading from Tennyson's "Ulysses," a non-controversial poem. However, it seems to me that such conferences are worthwhile in spite of their auspices.

Recently, Congress by amending the Federal Security Act of 1935 has increased the benefits of old age pensions from 75 to 100 per cent. Industry is working on methods to increase usefulness of older workers whose skill and experience are of great value. Labor is clamoring for increased retirement pensions and is making substantial progress. Politically, the aged are making their voices heard.

Recently, a college in New York, founded by a retired professor with a faculty of retired professors, has discovered their usefulness in the field of adult education. A consulting engineering company, made up of retired tcp flight engineers, has also set up offices in New York, and its members are proving their worth by reason of their seasoned experience. Thus, instead of stagnating in idle retirement, older people are re-channeling their efforts into fields useful to the community as a whole. Many cities are setting up recreational and consulting sources directed toward the solution of the problem.

According to a survey made among 3,000 Minnesota policy holders, only about one-third if given their choice, wanted to retire at 65; one-third wanted to ease off or change occupations; and one-third wanted to keep right on working. Of those that chose to retire, 60 per cent preferred to retire in their home towns. Of those that wanted to live elsewhere, most chose Florida with Southern California as a close second. The Pacific Northwest and the Arizona-New Mexico areas just about tied for third place. Forty-three per cent checked warm climate as their first or second consideration. Obviously this has a sound physiological basis. Sixty-two per cent preferred to live in a small town; 31 per cent preferred remote country areas; and only 7 per cent wanted to live in a large city.

In closing, I would like to direct your attention to our local problem and what is being done to solve it. Richmond is an unusually fortunate city for the aged. History and antiquity are venerated here because of the long continuity of families and business. Older men control most of the city's financial and professional life. Changes come about more gradually in a city whose roots lie in so glorious a past. According to Dr. Stieglitz, respect for the aged varies with the cultural age. The Chinese, whose culture is oldest, have what to us is an exaggerated veneration for the aged: namely, ancestor worship. The average American attitude toward the aged is nearer one of disrespect. Witness the common slang of the day for old people, "Hi, Pop," or "Okay, Grandma." Dr. Stieglitz further observes that disrespect for age is an index of the immaturity of our total culture. Buster Brown, he continues, would be a better national symbol than our white haired Uncle Sam. I am proud to say that in Richmond this attitude toward the aged is more mature and hence more respectful. Richmond then affords an unusually favorable environment for the aged. Richmond has a heart and has always done a good job in looking after the destitute and needy even though modern welfare-state advocates may not agree or approve its method.

In January, 1948, the Inter-Faith Council was asked to report on general plans then operating for older members of our local citizenry. This report, signed by Mrs. Donald Zimmerman, did much to spark the interest in geriatrics in Richmond. Later that year Dr. C. Howe Eller became the first chairman of a geriatrics committee of the Richmond Community Council Health Division. This committee, a sub-committee of the Community Council's Committee on Problems of the Aged, headed by Dr. E. W. Gregory of the University of Richmond, has gathered material and made plans for further study of the over-all problem. During the past year, under the auspices of the commmittee, two lectures on geriatrics for the junior medical students at the Medical College of Virginia were introduced for the first time in this state. These are now a regular part of the medical curriculum.

A survey of all nursing and home facilities for chronic disease was made by the City Health Department this year; 1,455 beds are at present available with 80 per cent occupancy, creating a total of 483,401 patient days. This number includes the City Home, Pine Camp, and private and charity nursing homes.

Richmond has about 14,000 citizens who are 65 years of age and older. This presents a real challenge. They represent not only a problem, but, if guided properly, a genuine asset of experience and wisdom. The Geriatrics Committee hopes to solicit the interest of Richmond's many churches and synagogues in helping to formulate group activities such

as work-shops for men, sewing circles for women, and companionship for all. Geriatrics is unlimited, and interest in it must be widely aroused not only among professional groups but among the population as a whole.

Although age is inevitable, at times depressing, occasionally catastrophic, we must not lose sight of the fact that so may be childhood and middle life. We can well adopt the philosophy of that great English bard, Robert Browning, when he said of age in his immortal Rabbi Ben Ezra:

"Grow old along with me!
The best is yet to be,
The last of life, for which the first was made:
Our times are in His hand
Who saith 'A whole I planned,
Youth shows but half; trust God: see all, nor be afraid!'"

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The author wishes to thank Mr. Clayton F. Mayo, statistician of Richmond Department of Health, for help in preparing statistics and slides.

1000 West Grace Street

New Type Needle Reduces Spinal Anesthesia Headache.

Lessening of headaches following spinal anesthesia with the use of a new needle in the administration of the anesthetic was reported in the Oct. 13 J.A.M.A. The needle, much finer and smaller than the customary one, has a sharpened, pencil-point-like tip, according to the authors of the article, Drs. James R. Hart and R. J. Whitacre, of the department of anesthesiology of the Huron Road Hospital, East Cleveland, Ohio.

Although a multitude of theories have been given for the causes of such headaches, Drs. Hart and Whitacre stated it is generally believed they follow leakage of cerebrospinal fluid through the puncture hole made by the needle in the outermost membrane of the spinal cord. This loss of fluid support from the brain is believed to cause tension on blood vessels and brain nerves, resulting in a headache. In a test, 2,070 patients were administered spinal anesthesia with an ordinary needle. One hundred and three of them (five per cent) complained of the typical spinal type of headache, the report stated. Of 3,489 patients on whom the pencil-point type needle was used, only 69 (two per cent) developed headaches.

The headaches which occurred following the use the pencil-point needle were, for the most part, shorter in duration and of less severity than those after use of the customary needle, the report added.

"These results are very encouraging and lend support to the opinion of earlier workers that such an approach may point the way toward a means whereby the percentage of postspinal headaches can be reduced," the doctors stated. However, they added, much more experience will be needed to confirm these findings.

XUM

MULTIPLE OSTEOCHONDROMATA OF THE HAND—
Report of a Case.

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and
B. K. MUNDY, M.D.,
Lynchburg, Virginia.

H. A. A., white, male, age 33, admitted to hospital November 22, 1948; discharged December 6, 1948. Occupation—odd farm work. Hospital number 2226.

Chief Complaint: Deformity of left hand.

Past Medical History: Measles, flu and whooping cough.

Present Illness: Patient injured left hand in sewing machine treadle at the age of 11 months. Has had continuous bony tumor of painless and not changing size and type since he can remember.

Physical Examination:

Head: No evidence of trauma.
Eyes: Pupils equal and active.
Nose: Good air passage.
Throat: Large tonsils present.
Teeth: Dirty and carious.
Chest: Clear to percussion and auscultation.
Heart: Not enlarged. No murmurs. Blood pressure 140/88.

Abdomen: Liver and spleen not palpable.
Extremities:
Left Hand: Tumors dorsum of left hand.
1. On 2nd metacarpal—size small orange.
2. On index finger—size marble.
3. On third finger—size marble.

Motion is free. Index finger extensor tendon and that of third finger displaced to medial side of finger.

X-Ray Left Hand—November 23, 1948.

The larger tumor of the four measured 5.5 x 4.6 x

3.7 cm. attached to the bone by a wide base type composed of bone differentiated into cancellous and cortical zones.

Operative Note: November 24, 1948.

Anesthesia: Sodium pentothal—1½ grams.

Operation started: 12:15 P.M.

Operation ended: 2:15 P.M.

Pre-Operative Diagnosis: Bone tumors left hand.

Operation: Removal of multiple bony tumors from left hand, posterior surface of middle and index fingers.

Post-Operative Diagnosis: Bone tumors left hand.

Findings and Procedure: Incision was made over large tumor on dorsum of hand down to and exposing the tumor which was removed from its base by osteotome, removing the cortex of the 2nd metacarpal bone which was thoroughly curetted down to the end

including the medullary canal. The tumor was attached to this bone for a distance of two-thirds of its length and a large mass of bone was then separated between the 2nd and 3rd metacarpal bone all of which was removed. The other tumor on the index and middle fingers were removed down to and including the cortex of the bone tendon. The skin was closed with silk. Dressing applied and patient left the operating table in good condition.

Progress Record:

11-28-48: Hand dressed. Clean.

11-30-48: Doing nicely. Hand dressed yesterday and found clean.

12-4-48: Stitches removed.

Discharge Note:

12-6-48: The skin wound has healed without any inflammatory reaction. The patient still has light dressing over the incised area. Discharged home to return in two weeks.

Micro: Osteochondromata.

Final Diagnosis: Osteochondromata, multiple, left hand.

Patient failed to return for post operative photographs of the left hand.

703 Church Street

EOSINOPHILIC GRANULOMA OF THE SKULL; REPORT OF FOUR CASES OF A BENIGN BONE LESION

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and
W. T. PRICE, JR., M.D.,**
Richmond, Virginia.

INTRODUCTION: About 72 cases of this disease (eosinophilic granuloma) which can occur practically anywhere in the skeleton, have been reported in the medical literature up to 1949 (Hill[1]). The lesion is commonly observed in children and adolescents, although some cases are seen in older individuals. Thomas Smith in 1865[2] was probably the first to report a patient of this type. When found in, for instance, the skull, it is necessary to have films made of most, if not all, of the bones of the skeleton before one is justified in stating that it is an isolated or single lesion in any individual case. The disease has a predilection for flat bones; apparently it is associated with abnormal lipoid metabolism also, and must occasionally, in children, be distinguished from Hand-Schuller-Christian disease which in turn is associated with exophthalmos, polyuria (diabetes insipidus) and feeble-mindedness, features not found in eosinophilic granuloma.

The modern recognition and description of the disease (eosinophilic granuloma) was first recorded only a decade ago. In 1940, separate reports by Otani and Ehrlich[3] and by Lichtenstein and Jaffe[4], within two months of each other, established the lesion as a disease entity. These authors described a solitary lesion of bone in which the medullary space was replaced by a granuloma packed with a multitude of eosinophiles. Hatcher[5] also, in 1940, described this lesion in three children, the preoperative diagnosis being sarcoma of long bones.

The cause of the disease is uncertain. Local trauma and an infectious agent, possibly a virus—both have been indicted as etiological factors. There are no symptoms of generalized illness, no fever, malaise, loss of weight or anemia. The patient usually consults his physician because of local symptoms, associated with the growth of the bony tumor, or there may be *no* symptoms at all and the disease is accidentally discovered during routine examination of roentgenograms. *Localized tenderness,* even, occasionally, *exquisite pain,* at the site of the lesion, is an important symptom and was present in all four cases to be presented in this paper.

The roentgenograms usually reveal a localized, sharply punched-out area of bony rarefaction, with no surrounding reaction of bone (Osborne, Freis and Levin[6]).

Cases with visceral lesions (jejunum) have been observed by Polayes and Krieger[7] who concluded (1950) that at present there is no evidence to indicate any relationship between this intestinal type of eosinophilic granuloma and that of bone marrow more frequently seen and reported in the literature. They did stress, however, that similar cases (eosinophilic granuloma of the jejunum) have probably been overlooked in the past. They believe their case to be the first of its kind in medical literature although other chronic types of intestinal granulomas have long been described. Interesting cases of rib and femur involvement have recently been reported.[8, 9]

In many of the cases of eosinophilic granuloma of bone, a very mild eosinophilia varying between 4 and 10% has been found, particularly in *early* cases, according to Campbell and Alexander[10]; this was not true, however, in our 3 detailed cases (*q. infra*).

There has been no other consistently abnormal laboratory finding although studies of blood lipids, blood cholesterol, total protein of blood, serologic tests for syphilis and urine tests for Bence-Jones protein have been repeatedly carried out.

PATHOLOGY: Eosinophilic granuloma usually starts as a well-localized lesion in the medullary cavity of a bone with a tendency to erode, expand and perforate the cortex. In the calvarium, it may erode either inward or outward and several cases have been recorded in which a considerable area of

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the dura and even the brain underlying the bone lesion have been directly involved. Baker and Fisher[11] have reported four cases (1948). They found in one case (*Case I*) direct invasion of the cortex of the brain. One cerebral convolution (left parietal) was excised in a circular manner in order to remove the greater portion of the lesion. The tissue was firm, gray and adherent to the dura. Microscopically, an extensive cellular infiltrate, with a predominance of eosinophilic leucocytes and many lymphocytes, occurred. A few cells may have foamy cytoplasm and large phagocytic cells may be present. Occasional multinucleated giant cells are seen. Postoperatively, the patient had Jacksonian convulsions (right-sided) and continued to have them for several years in spite of grains 2 of phenobarbital a day. The attacks disappeared when the total fluid intake was reduced. Another of their cases (*Case III*) had bilateral choked disks (1 diopter) although the granulomatous mass had only slightly penetrated the dura after involving both tables of the skull. X-ray therapy was given post-operatively and more than four years later the patient was working steadily without convulsions although he had had Jacksonian seizures for a considerable period post-operatively.

At the time of operation, the lesion may grossly seem malignant, appearing grayish pink, soft and friable, usually invading both tables of the skull; often the dura and even the brain beneath may be involved.

Gross and Jacox[12] believe that Hand-Schuller-Christian disease and eosinophilic granuloma of bone have common features in that both conditions are associated with destruction and replacement of normal tissue by a granulomatous proliferation in which endothelial cells predominate. Eosinophilic participation occurs in both conditions. Some pathologists believe that eosinophilic granuloma is a type of reticulo-endotheliosis and that it is identical with Hand-Schuller-Christian disease. Mallory[13] believed the two to be variants of each other, a third variant being Letterer-Siwe's disease which, in infancy, is rapidly progressive and fatal. A review of pertinent papers on the pathology of these three diseases suggests a definite relationship between them.

Jaffe and Lichtenstein[14] also concluded (1944) that the three conditions just mentioned actually are different clinico-anatomic expressions of the same basic disturbance. They said that the three diseases are peculiar inflammatory reactions to the same, as yet unknown, agent of infection and that individual lesions are characterized by the presence of large numbers of histiocytes. Geschickter and Copeland[15], Snapper[16], and Coley[17] fully discuss this disease entity in their well-known authoritative monographs on bone diseases.

DIFFERENTIAL DIAGNOSIS: The following lesions are often considered as possibilities preoperatively in the reported cases of eosinophilic granuloma: metastatic carcinoma, gumma, tuberculoma, vascular tumor and Boeck's sarcoid. In addition, Hill[1] has added to this list: meningioma, epidermoid cyst, osteomyelitis, Ewing's tumor of bone, osteitis fibrosa cystica, multiple myeloma and osteogenic sarcoma. Still other lesions to be considered in the differential diagnosis are suggested by Osborne, Freis and Levin[6], viz., solitary bone cyst, enchondroma, Gaucher's disease, giant cell tumor of bone, neuro-fibromatosis and gout (especially in lesions of hand and foot bones).

REPORT OF CASES

CASE I: The patient, number B.11841, a 19-year-old white female, was admitted to the Medical College of Virginia Hospital on June 28, 1943. Her chief complaint was "tumor on my head." She was supposedly in good health until one month prior to admission, when she developed pain in the top of her head just to the right of the midline. Several days later the patient began to notice a small "knot" which was progressively increasing in size. She had experienced no generalized headache, but the *slightest touch* of the scalp over the area of the lesion produced exquisite pain. For a short time before admission the patient experienced mild tenderness in the right ear. There was no history of deafness, vertigo, visual disturbance, or other significant neurological symptoms.

Physical examination revealed a mass 3 cm. in diameter and approximately 1½ cm. elevation in the right parietal scalp near the midline. The scalp in this area was exquisitely tender, but there was no perceptible redness or increased temperature in the skin. Neurological examination was entirely negative. Routine laboratory work revealed a white count of 6,700 with 62% polys, 32% lymphocytes, 5% monocytes, and 1% eosinophils. Urinalysis and blood Wassermann were negative. X-ray films of

the skull revealed a punched-out mass, approximately 2 cm. in diameter in the right parietal bone.

On June 30, 1943, the patient was operated upon under local anesthesia, using 1% procaine. A 7 cm. curved linear scalp incision was made just posterior and above the 3 cm. scalp mass. The scalp flap was reflected back, the galea was found to be adherent over an area approximately 2 cm. in diameter. This was dissected free, exposing a soft tissue mass which comprised the tumor. The neoplasm was excised in toto and sent to the laboratory for examination. A trephine opening was then made adjacent to the bony lesion in what was apparently normal bone. The diseased area was rongeured away along with the rim of what was apparently normal bone. The dura was pale and healthy in appearance and there was no evidence of tumor invasion. The wound was closed and the patient returned to the ward in good condition. The pathological (microscopic) diagnosis was eosinophilic granuloma. The postoperative course was uncomplicated and the patient was discharged on July 8, 1943, eight days after operation.

CASE II: The patient, number B.50446, a 24-year-old white female, was admitted to the Medical College of Virginia Hospital on August 23, 1948, with a history of right frontal headaches of four months' duration. She also had noticed a small, hard swelling in the lower right frontal region which, according to the patient, varied in size, and on occasion caused swelling with bluish discoloration of the skin adjacent to the right eye. Pain over the area of swelling had been so severe that it prevented the patient from sleeping, but it was not of such intensity that it could not be relieved by aspirin. There were no other complaints except anorexia with a weight loss of 25 lbs. in the year prior to admission. There was no history of visual disturbance, dizziness, tinnitus, memory loss, weakness, fainting, vertigo, or other significant neurological symptoms.

Physical examination revealed a very nervous, tense, white female, who was not too cooperative and answered questions reluctantly. There was an exquisitely tender pea-sized nodule palpable in the right frontal scalp and skull. This nodule apparently was adherent to the bone but did not appear to be adherent to the skin. There was moderate tenderness for a one inch radius about the nodule. There was no erythema and no increased skin temperature about the nodule. The routine laboratory work on admission revealed a white count of 7,700, with 71% polys, 1% eosinophils, 25% lymphocytes and 3% monocytes. The urine was negative for Bence-Jones protein the non-protein nitrogen was 25 mgs. per cent. The blood Wassermann was negative. The total protein; the non-protein nitrogen was 25 mgs. per cent. of albumen and 3 grams per cent of globulin. The hemoglobin was 12.6 grams. The sedimentation rate was 13 mm. in sixty minutes. Skull X-ray examination revealed the typical rarefied "punched-out" lesion in the right frontal region which is highly characteristic of eosinophilic granuloma (Fig. 1).

Fig. 1. Case II. Right lateral skull film showing the typical punched-out rarefied appearance of the lesion in the right frontal area that is characteristic of eosinophilic granuloma.

The patient was operated upon on August 26, 1948, with a preoperative diagnosis of possible eosinophilic granuloma of the right frontal bone. Under I. V. sodium pentothal anesthesia, an S-shaped scalp incision was centered over the area of tenderness. After the scalp flap had been reflected backward, a raised area approximately 1 cm. in diameter was exposed. This consisted of soft tissue of a grayish-yellow color. The bone about the margin was ragged and thin, with both tables of the skull apparently involved. A biopsy was taken and the lesion subtotally removed by curettage and with the rongeurs. The scalp incision was then closed with a presumptive diagnosis of eosinophilic granuloma of the bone. Four days later the patient was returned to the operating room

where the previous S-shaped incision was reopened. It was elected at this time to carry out a total removal. A partial craniectomy was then done by use of the rongeurs, excising all the grossly involved bone and a small rim of apparently normal bone about this to insure complete removal. A skull defect approximately 3 cm. x 3 cm. in extent remained. It was noted at this point that the dura was involved by a granulomatous reddish-gray lesion to an extent of about 1½ cm. The dura was opened and the involved dura was totally excised, including a rim of normal appearing dura. The total dural defect measured 2 cm. Inspection of the under surface of the dura revealed a shiny apparently normal dura. The arachnoid was intact and there was no evidence of intradural or cerebral involvement. A small polythene graft measuring 3 cm. x 3 cm. was fastened and sutured to the dural margins. The incision was then closed and the patient returned to her room. The pathological report was eosinophilic granuloma of the right frontal bone (Figs. 2, 3). The postoperative course was uncomplicated and the patient was discharged on September 4, 1948, nine days postoperatively.

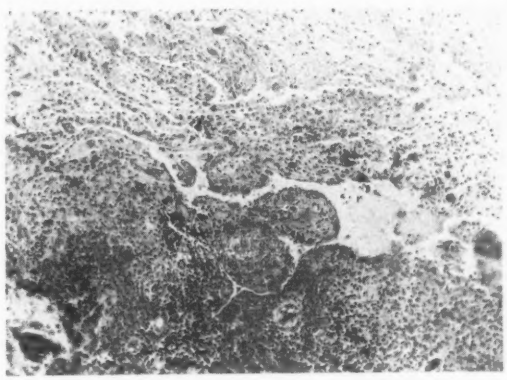

Fig. 2. **Case II.** Low power microphotograph of tissue removed from right frontal bone. It resembles exuberant granulation tissue at this magnification. H and E x 30.

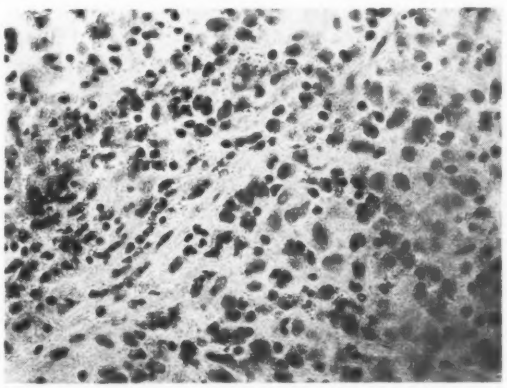

Fig. 3. **Case II.** Much higher magnification of tissue removed in Case II. The section shows young granulation tissue, rich in fibroblasts and infiltrated with eosinophiles and an admixture of lymphoid cells. H and E x 400.

CASE III: The patient, number B.55627, a 21-year-old white female, was admitted to the Medical College of Virginia Hospital on November 24, 1948. Her chief complaint was "a tender spot on my head." The patient was supposedly in good health until seven weeks prior to admission, at which time she noticed a tender area just above the hairline in the left side of her forehead, while combing her hair. A few days later this area became swollen and red. The tenderness persisted and became more severe. During the two weeks prior to admission, the patient had infrequent frontal headaches but they were noticeably of increasing severity. There was no history of nausea, vomiting, visual disturbances, tinnitus, deafness, vertigo, or other neurological complaints.

System review is entirely negative except for a painful nodule in the left labia majora of three days' duration. This had been treated by a local physician with hot sitz baths of magnesium sulfate.

Physical examination revealed a temperature of 100°, pulse 80, respiration 20, blood pressure 110/85. The patient was an alert, cooperative, white female, of apparently normal intelligence. There was a 2 cm. area of extreme tenderness in the left frontal scalp, just posterior to the hairline. There was no perceptible reddening of the skin over the area but slight elevation of the scalp over the area of tenderness could be seen. The neurological examination was entirely negative. The only other significant finding on physical examination was a tender oval mass, approximately 4 cm. in diameter, in the left vulvo-femoral fold. A diagnosis of abscess of the left vulvo-femoral fold was made by the gynecology department. This was incised and drained in the operating room on November 27, 1948.

X-ray examination of the skull revealed a punched-out, rarefied lesion in the left frontal bone, approximately 2 cm. in diameter. A chest film was negative both for pulmonary and bony disease. Routine hemogram on admission revealed a total white count of 12,200, with 79% polys, 1% basophils, 16% lymphocytes, 4% monocytes. The hemoglobin was

15.1 grams, with 5 million red blood cells per cu. mm. The urine specimen on admission showed 12 to 15 Wbcs. per high power field with a 1 plus albumen. The blood Wassermann was negative. The diagnosis on admission was eosinophilic granuloma involving the left frontal bone, and incidental abscess of the left vulvo-femoral fold.

On December 1, 1948, the patient was operated upon, using intravenous sodium pentothal anesthesia. A 6-7 cm. incision was made transversely just anterior to the coronal suture on the left side. To obtain better exposure, however, it was necessary to extend this incision in a sagittal direction at the medial end. This adequately exposed the skull lesion, which consisted of a defect approximately 1½ cm. in diameter, which apparently involved both the inner and outer tables. The area of defect was filled with a grayish-red, soft, friable, granulomatous lesion of moderate vascularity. The bone edges were ragged but not particularly soft. The pericranium directly over the lesion appeared to be involved. The pericranium and involved skull area were excised and a specimen sent to the pathology laboratory for frozen section diagnosis. This revealed eosinophilic granuloma; it was elected to carry out a complete excision. A trephine opening was placed in the frontal bone adjacent to the defect and a partial craniectomy carried out around the defect, using bone rongeurs. The excision of bone about the defect was carried out well beyond the margins of the lesion. Total extirpation of the lesion was apparently carried out; the dura did not appear to be involved. It was decided at this time to insert a tantalum plate, which was done. The permanent (H and E) pathological sections confirmed the diagnosis of eosinophilic granuloma (Fig. 4). The post-operative course was essentially uncomplicated and the patient was discharged on December 15, 1948, two weeks after operation.

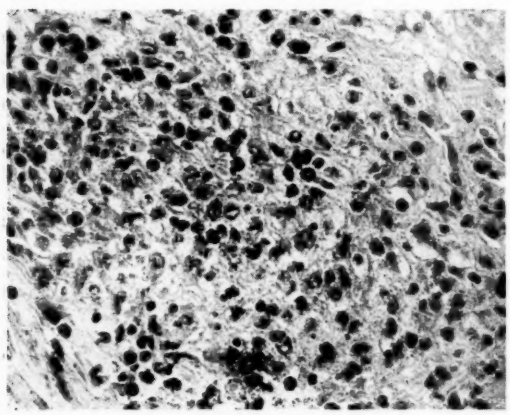

Fig. 4. Case III. Microphotograph of tissue removed from left frontal bone. The appearance is similar to that of Case II (see Fig. 3). This section also shows granulation tissue rich in young fibroblasts and heavily infiltrated with eosinophiles and mononuclear phagocytes (typical microscopic appearance of eosinophilic granuloma). H and E x 400.

CASE IV: This patient was not operated on at the Medical College of Virginia Hospital but was seen originally by our associate, Dr. C. E. Troland, at McGuire General Hospital, Richmond. It was the case of a young, adult white male, on whom he operated several years ago, who had a large tender mass in the occipital bone, which Dr. Troland excised and which proved to be, miscroscopically, a typical eosinophilic granuloma. Approximately one year after craniotomy, the lesion again appeared in the mandible (X-ray verification) and was successfully treated by irradiation only, at the Medical College of Virginia Hospital. So far as is known to us, the patient has been well since that time.

TREATMENT

Therapeutic enthusiasts are somewhat abashed by such statements as that of Hill[1]: "*Spontaneous* healing is the rule in the course of months, with or without treatment." Likewise, Jaffe and Lichtenstein[14] have observed the healing of this disease in cases that have received no treatment, having first verified the disease by biopsy only of the typical lesion seen in the roentgenograms. On the other hand, no less an authority than Copeland[18] states that "Spontaneous healing is rare," and recommends surgical excision or curettage, often combined with mild X-ray treatment; the latter alone may suffice after biopsy. In this latter opinion, the present writers concur. In women with frontal bone lesions, surgical excision *without X-ray treatment* is usually preferred to avoid the risk of epilation, as in *Case III* reported in this paper. Baker[11] believes, however, that the lesion undergoes better repair eventually if, at the time of biopsy, curettage is not done and the lesion is treated solely by roentgen ray therapy. This is due, he states, to better bony proliferation from a spicular matrix. He recommends X-ray therapy rather than nothing at all in these cases.

Of prime importance in the entire consideration of this disease is that it is a *benign bone lesion,* a happy

finding, as often at the onset of the study of the individual case, very serious malignant bone lesions of one type or another must be considered in the differential diagnosis. No deaths directly attributable to the disease have been reported to date in the literature.

SUMMARY

1. Eosinophilic granuloma, a benign lesion of bone, is considered, including a review of the pathology, symptoms, diagnosis, differential diagnosis and treatment of this interesting disease entity which has only rather recently been described in the literature.

2. Four cases of this lesion (involving skull and (or) mandible) are reported.

N.B. The interpretation of the microphotographs (Figs. 2, 3, 4) was kindly supplied by Dr. Saul Kay, Surgical Pathologist, Medical College of Virginia, Richmond.

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XUM

ELECTRO SHOCK THERAPY—CENTRAL STATE HOSPITAL

M. S. BRENT, M.D., Superintendent,
and
R. W. O'GORMAN, M.D.,
Petersburg, Virginia.

Treatment reports of 500 psychiatric patients with all types of mental illnesses over the year period of 1950.

Electro shock is an electric procedure and should be given only when it may be expected to shorten the duration of a mental illness. All conditions of patients were appraised after a series of twelve treatments. More treatments were given to manics than to any class of patients. Patients who responded well were given fewer treatments. Most given were twelve, the lesser, three. If the patient didn't respond after twelve treatments, it was discontinued.

CONTRAINDICATIONS FOR SHOCK THERAPY

A. Cerebral arteriosclerosis.
B. Coronary diseases.
C. Over 65 years of age.
D. Pulse below 40 and above 100.
E. Epilepsy.
F. Blood pressure above 180 systole and above 100 diastole.
G. Fever due to any cause.
H. Chronic nephritis.

PRESHOCK TREATMENTS

A. Vitamins, vigrans, one in the morning and one at night.

B. Two teaspoonsful of milk of magnesia the night before.

C. The patient is allowed to have breakfast as shock therapy is given for at least four hours after intake of food.

D. A physical examination done on all patients previous to shock.

POSTSHOCK TREATMENTS

A. The patient is allowed to sleep as long as he likes.

B. The patient isn't allowed to leave the shock bed until fully recovered.

C. The patients are examined for possible injury.

No deaths, directly or indirectly, have been contributed to shock treatments. Sixteen patients had epistaxis which was easily controlled. Ten slight lacerations of the tongue; none required sutures.

TECHNIQUE

Each patient before being placed on the bed in preparation for shock is examined by a physician for any present pathology that would eliminate the shock treatment. A soft pillow is placed under the patient's head; another pillow under the body and another under the feet. Five attendants, if that number can be spared at the time from other services or two attendants and three oriented and clear patients who are previously taught how to hold a patient, are used as assistants. No restraints are used on the arms or legs of the patients. Previous experience has shown that restraints such as straps or sheets have a tendency to act as an irritant to the patient during a convulsion. The voltage used, usually ranges from 100 to 140, and the duration of time from 3 to 5 seconds. The usual voltage that takes care of about 75% of the patients is 120 for the duration of 3 seconds. After all, what we are looking for is the voltage that will put the patient into a good strong convulsion. During the convulsion there are two men on either side (one at the shoulders and one at the legs) of the patient and one man with a towel holding up the chin of the patient and also holding the mouth gag in place to eliminate the possibility of the patient biting his tongue. A tongue depressor with gauze wrapped

RESULTS OF SHOCK TREATMENT IN 500 CASES RECOVERED OR GREATLY IMPROVED

	Cases	No.	Per Cent
Manic Depressive Psychosis Manic Type	186	98	53%
Manic Depressive Psychosis Depressed Type	122	71	58%
Involutional Psychosis	33	12	36%
Dementia Praecox, Catatonic	85	63	74%
Dementia Praecox, Hebephrenic	14	6	43%
Feeding and Disturbed from any Source	60	51	82%
	500	301	60%

around it is used as a mouth gag. The attendants are trained not to exert any pressure on the patient but to rise and fall with each movement of the patient. After the convulsion has completely subsided, the patient is turned on the right side and two attendants stay in the room until the patient has completely recovered and is able to stand and walk on his own. The patient is again examined by the ward physician for possible bruises and lacerations, especially of the tongue.

SUMMARY

A. Of the 500 cases given electro shock therapy, 60% were recovered or greatly improved.

B. More manics were treated than any other form of mental illness----------308
Manic depressive psychosis, manic type--186
Manic depressive psychosis, depressed type 122
The manics, 53% recovered or greatly improved.
The depressed type, 58% recovered or greatly improved.

C. The greatest amount of improvement was shown in dementia praecox, catatonic Type—74%.

D. Feeding problems and disturbed patients from other sources than those listed above had a greater percentage, 82% recovered or greatly improved. This is not a true picture as we didn't know what part vitamins played in the feeding problem and how soon the disturbed patients from any other source would have recovered without the electro shock therapy.

E. Visitors at the hospital have often remarked what a quiet place Central State Hospital is, taking into consideration that this is a mental institution. It has been the policy of the medical staff to closely watch the patients and to eliminate a possibility of becoming disturbed with electro shock therapy. Hydrotherapy and restraints have been almost eliminated by the use of shock therapy. It has been the impression and experience that electro shock treatments play a more important role in the treatment of mental patients than any other form of therapy. The writer feels that the chart shown in this article gives a pretty fair and accurate index as to the merit and necessity of electro shock therapy. With a percentage of 60% recovered, or greatly improved, with its use, the writer feels it is a must in every mental institution.

Competitive Athletic Leagues Not Desirable for Children.

Highly organized competitive athletic leagues are undesirable for children and youth of elementary and junior high schools, according to Donald A. Dukelow, M.D., and Fred V. Hein, Ph.D., consultants to the American Medical Association Bureau of Health Education, in November To-Day's Health.

Parents, they pointed out, want their children to have the best possible program of physical and health education, yet many reject the facts derived from exhaustive study of children in the first nine grades. The doctors said they wondered if this is because parents "prefer to bask in the reflected glory heaped upon immature children by an unthinking public which demands the last ounce of effort to win for good old X Junior High School."

According to the article, physical education in school should stress a well-rounded program of instruction for all children, and, for as many as possible, an interesting, extensive program of intramural competition in team, dual and individual sports. This should be supplemented by sports days and play days.

The country's leading educational and medical groups, the doctors stated, have recommended that "interscholastic leagues should be confined to senior high schools. Interschool activities for junior high school pupils should be limited to occasional meets or games. Junior high school boys should not compete in American football. An extensive program of intramural activities is strongly recommended for these students."

XUM

PUBLIC HEALTH

MACK I. SHANHOLTZ, M.D.,
State Health Commissioner of Virginia.

Public Health As a Career

With rapid expansion in the field of Public Health, physicians are urgently needed to fill existing vacancies and anticipated new positions. Part of this expansion is due to changing concepts regarding the range of public health functions. Public health physicians along with practicing physicians are today, more than ever before, concerned with the problems of chronic diseases and the physical, mental and emotional aspects of aging. The most recent response to the major challenge of chronic disease and disability was the founding in 1949 of a permanent Commission on Chronic Illness by the American Medical Association, the American Hospital Association, the American Public Health Association and the American Public Welfare Association.

As the scope of Public Health increases, there is a continuing demand for services of physicians with special training. Counties and cities throughout the country are recognizing this necessity for appointing such trained men to direct their health departments.

The establishment of a Specialty Board in Preventive Medicine and Public Health by the Council on Medical Education and Hospitals of the American Medical Association gives a career in public health the recognition of a specialty status.

A noted leader in Public Health, Dr. C. E. A. Winslow, sums up the program of public health in the following statement:

> "Public health is the science of preventing diseases, prolonging life and promoting physical and mental efficiency through organized community effort."

MONTHLY MORBIDITY REPORT OF THE BUREAU OF COMMUNICABLE DISEASE CONTROL

	Nov. 1951	Nov. 1950	Jan.-Nov. 1951	Jan.-Nov. 1950
Brucellosis	5	8	76	60
Diarrhea and Dysentery	253	184	2,948	3,642
Diphtheria	41	18	167	173
Measles	153	78	13,993	2,685
Meningitis (Meningococcal)	8	15	110	111
Poliomyelitis	16	82	251	1,156
Rocky Mountain Spotted Fever	1	1	60	75
Scarlet fever	101	93	891	818
Tularemia	0	3	35	37
Typhoid and Paratyphoid	11	5	63	84

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President MRS. HERMAN W. FARBER, Petersburg
President-Elect—
MRS. THOS. N. HUNNICUTT, JR., Newport News
Recording Sec'y MRS. L. BENJ. SHEPPARD, Richmond
Corresponding Sec'y MRS. CARNEY C. PEARCE, Petersburg
Treasurer MRS. KALFORD W. HOWARD, Portsmouth
Publication Chairman MRS. ROBT. H. DETWILER, Arlington

Legislative Notes

The convening of the Virginia General Assembly is fast approaching. In this connection I should like to say that in a recent meeting of the Virginia Women's Council of Legislative Chairmen of State Organizations, Colonel E. Griffith Dodson, Clerk of the House of Delegates, urged that we see our representatives *at home* before they come to the Assembly to let them know our views regarding legislative measures in which we are interested.

Therefore, I urge each Auxiliary member personally to see her own delegates and senators, and ask them to give careful consideration to the Virginia health needs outlined by the Virginia Council on Health and Medical Care. The Council's legislative program has been well thought out and well planned with a view to bettering conditions in the State as a whole. This program is outlined in their Public Opinion Report Number 10 and may be secured by writing Mr. Edgar Fisher, Executive Secretary for the Virginia Council on Health and Medical Care, 102 East Franklin Street, Richmond, Virginia.

Doctor John W. Cline, President of the American Medical Association, in speaking to the Woman's

Auxiliary to the Southern Medical Association in Dallas, Texas, in November said: "You women should remember that you are first *citizens* before you are doctors' wives." Let us remember this and take an active interest in government, local, state, and national during the coming year. By all means be sure to vote in 1952.

LUCIA K. EMLAW, (MRS. MAYNARD R.)
State Chairman of Legislation

Reports from Auxiliaries.

ARLINGTON

Annual Dinner-Dance

The Woman's Auxiliary of the Arlington Medical Society held its annual Doctor's Dinner-Dance on November 16th at the Washington Golf and Country Club with reservations for 75 couples.

Mrs. John T. Hazel, President, greeted the guests and members and introduced the speaker, Dr. Stacy T. Noland of Arlington.

Mrs. Albert J. Orlosky, Chairman of the Social Committee, made all arrangements for the very successful affair.

Benefit TB Handicraft Sale

A sale of handicraft made by TB patients was sponsored by the Woman's Auxiliary to the Arlington Medical Society on November 20, December 1 and December 3rd, at the Arlington Trust Company Bank and the Southern Electric Appliance Inc. in Clarendon.

The attractive leather billfolds, belts, earrings, hand crocheted bedspreads, tablecloths, centerpieces, rugs, corde bags, luncheon sets, etc. were made by convalescents in the homes of Arlington and around Staunton, in the Blue Ridge, Catawba, and Pine Camp Sanatoriums.

Proceeds from the two sales amounted to $432.20, which was returned to the individual patients according to the price of their articles. This amount was more than double that realized last year from the first sale of TB handicrafts attempted by this Auxiliary.

Thanks go to the staff of the Arlington TB Association for their splendid assistance in planning and conducting this project.

WARWICK

The annual bazaar of the Auxiliary to the Warwick County Medical Society was held at the Elizabeth Buxton Hospital on November the 14th from 9:30 A.M. to 4:30 P.M. Financial report is not complete at this time.

CAMMIE DICK (MRS. MURRAY)
Reporter

RICHMOND

The Woman's Auxiliary to the Richmond Academy of Medicine held its annual Public Relations luncheon on Friday, November 16, at the Academy Building. Presidents of various other women's organizations of Richmond were invited and 25 attended. Other guests were: Mrs. J. M. Booker, State Public Relations Chairman, Mr. Richard Nash, Assistant to the Director of Public Relations for the Medical Society of Virginia, Mrs. Bette Orsini from the Richmond News Leader, and Mrs. Edna Barnett, Club Editor for the Richmond Times Dispatch. Sixty-five of our own members were present.

Dr. Vernon W. Lippard, Dean of the Department of Medicine of the University of Virginia, was speaker at the meeting, discussing health needs in the State. "The production of good physicians is the most important factor in maintaining good health", Dr. Lippard said. "They can be produced only through good schools with good facilities. No health program can be better than the people who run it."

Dr. Lippard reported the legislative program for 1952 of the Virginia Council on Health and Medical Care. The program calls for expansion of services in the health fields of tuberculosis, scholarships, mental health, cancer, public health, extension service, and medical schools. He said: "Only through the adequate support of citizens of the State can we continue our health progress."

Mrs. Thos. W. Wheeldon was program chairman and the luncheon hostesses were: Mrs. John Archer, chairman; Mrs. W. F. Cavedo, Mrs. William Spencer, Mrs. John Stevens and Mrs. Robert Trice.

LUCIA K. EMLAW (MRS. MAYNARD R.)
President-Elect

SOUTHWESTERN VIRGINIA

The 1951-1952 Officers of the Auxiliary are:

Society's Committee—Dr. A. P. Jones, Roanoke, Dr. James Chitwood, Pulaski, and Dr. James Suter, Abingdon.

President—Mrs. W. C. Caudill, Pearisburg

President-Elect—Mrs. James King, Radford

Vice-President—Mrs. C. C. Hatfield, North Holston

Secretary—Mrs. J. Glenn Cox, Hillsville

Treasurer—Mrs. A. B. Graybeal, Marion

Parliamentarian—Mrs. C. F. Manges, Blacksburg

Historian—Mrs. Giles Gilmer, Lebanon

Corresponding Secretary—Mrs. E. L. Bagby, Pearisburg

The goals for the year are increased membership and nurse recruitment.

NORTHERN NECK

Dr. J. Powell Williams, of Richmond, was the guest speaker at the Fall meeting of this Auxiliary, which met at The Tides Inn, on Thursday, October 25th. Dr. Williams used as his subject, "Medical Emergency in Civilian Defense".

The President, Mrs. J. Motley Booker, of Lottsburg, was pleased to report that this Auxiliary was the only one in the State whose membership was paid up 100% and in good standing.

The Officers for the coming year were elected as follows: President, Mrs. J. Motley Booker, Lottsburg; President-elect, Mrs. L. S. Liggan, Irvington; Vice-President, Mrs. E. T. Ames, Montross; Secretary, Mrs. P. C. Pearson, Warsaw; Treasurer, Mrs. M. B. Lamberth, Jr., Kilmarnock; Corresponding Secretary, Mrs. R. E. Booker, Lottsburg; Historian, Mrs. C. Y. Griffith, Machodoc; and Parliamentarian, Mrs. M. H. Harris, West Point. The following committee chairmen were named: Publicity, Mrs. M. B. Lamberth, Kilmarnock; Today's Health, Mrs. W. H. Matthews, Irvington; Bulletin, Mrs. A. B. Gravatt, Jr., Kilmarnock; and Cancer Control, Mrs. R. T. Arnest, Hague.

Following the business meeting, the ladies were guests of the doctors for the annual banquet.

NORTHAMPTON-ACCOMACK

The Auxiliary met at the home of Mrs. J. L. DeCormis on October 16. Following a dessert course, there was a business meeting which included reports of committee chairmen, summarizing the year's work. Mrs. DeCormis gave a report on the recent meeting at Virginia Beach, at which talks were given by Dr. C. L. Harrell, President of the State Society, Mrs. C. M. McCoy, State Auxiliary President, and Mrs. Walquist, National Auxiliary President. After these reports, the installation of new officers took place, Mrs. W. T. Green presenting the gavel of office to Mrs. John Wise Kellam, the incoming president.

Other officers and Committee Chairmen for 1952 are:

President Elect—Mrs. John R. Hamilton, Nassawadox

Secretary—Mrs. W. Carey Henderson, Nassawadox

Treasurer—Mrs. John Rodgers Mapp, Nassawadox

Today's Health—Mrs. John R. Hamilton, Nassawadox

Historian—Mrs. J. Walker Jackson, Shadyside

Legislative—Mrs. J. L. DeCormis, Accomac

Public Relations—Mrs. Holland Trower, Eastville

Leigh-Hodges-Wright Memorial—Mrs. Mihalyka, Eastville

Jane Todd Crawford Memorial—Mrs. Harry L. Dencon, Jr., Nassawadox

Cancer Control—Mrs. Sheppard K. Ames, Cape Charles

Bulletin—Mrs. J. Fred Edmonds, Accomack

BOOK ANNOUNCEMENTS

Practical Clinical Psychiatry. By EDWARD A. STRECKER, A.B., A.M., Sc.D., Litt.D., LL.D., M.D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; FRANKLIN G. EBAUGH, A.B., M.D., Professor of Psychiatry, University of Colorado, School of Medicine; Director, Colorado Psychiatric Hospital; JACK R. EWALT, M.D., Professor of Neuro-Psychiatry; Administrator of Hospitals, University of Texas Medical Branch, Galveston. Section on Psychopathologic Problems of Childhood by LEO KANNER, M.D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine. Seventh Edition. The Blakiston Company, New York, Philadelphia and Toronto. 1951. 506 pages, 35 figures, 14 tables. Cloth. Price $7.00.

Review of Physiological Chemistry. By HAROLD A. HARPER, Ph.D., Professor of Biology (Biochemistry), University of San Francisco; Lecturer in Surgery, University of California School of Medicine; etc. Third Edition. University Medical Publishers, Palo Alto, Calif. 1951. 260 pages. Price $3.50.

This is a concise but comprehensive presentation of some of the fundamentals of physiological chemistry. It should prove helpful to those wishing to review the subject in preparation for state, national or specialty boards, or to the graduate or clinician who may wish an abbreviated but up-to-date review of this rapidly advancing field. Students may find it a useful companion to, but not a substitute for, their textbooks. L.D.A.

THE MEDICAL SOCIETY OF VIRGINIA

Headquarters Building

THE headquarters building of The Society is a handsome, well-constructed, thirteen room house which has always been kept in good condition. Its appearance belies its stated age of forty years. The first floor is sufficiently large to permit the joint activities of The Society and the VIRGINIA MEDICAL MONTHLY being carried out on one level.

In adapting the building to its new needs, fortunately no structural changes above the basement were necessary. The chief changes involved painting, papering, sanding floors, new electric fixtures, applying asphalt tile to several rooms, installing cabinets, repairing and purchasing draperies, obtaining Venetian blinds and converting the back yard into a parking space with asphalt paving and a new fence. Furnishings for the reception room and rugs for this room and the hall were purchased. The original draperies and an Empire mirror over the mantle in the reception room were purchased with the house.

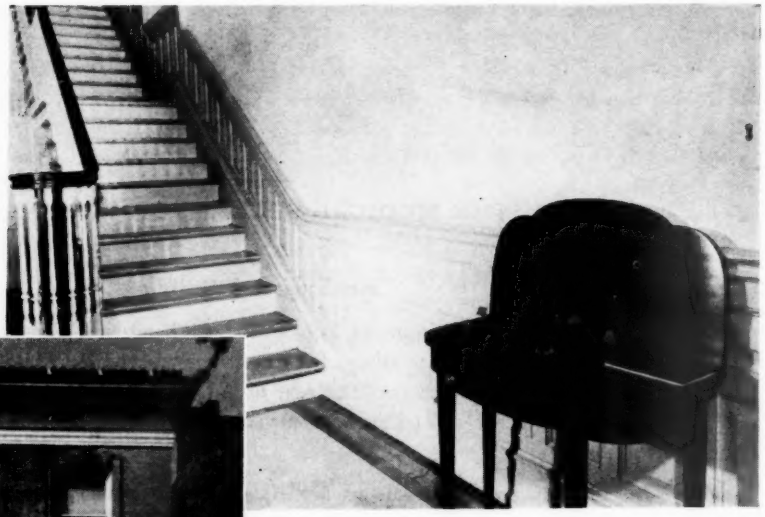
The Woman's Auxiliary of The Medical Society of Virginia generously presented the inlaid console table which was greatly needed in the front hall.

The heating plant was antiquated, an old furnace and an automatic stocker furnishing uncertain warmth. In view of this a new oil burning furnace was installed this summer. Since storage space for the numerous records of The Society had never been adequate, a large segment of the basement was partitioned off with suitable shelf space. These major changes give the Society an efficient and distinctive headquarters.

The front room on the second floor has been rented to the Virginia Academy of General Practice, effective January 1, 1952. It is anticipated that the other rooms on the second floor and a part of the third floor will be rented to suitable tenants.

It is hoped that the members of The Medical Society of Virginia will visit their new headquarters at their first opportunity and avail themselves of the facilities it affords. Visitors will find the parking space in the rear of the building of aid in this crowded section of Richmond.

XUM



Entrance Hall

1105 West Franklin Street

Reception Room

Executive Secretary's Office

The VIRGINIA MEDICAL MONTHLY and Membership Records

Public Relations Office

XUM

MEDICAL SOCIETY OF VIRGINIA

Public Relations

A.M.A. Public Relations Conference

The 4th Annual Medical Public Relations Conference of the American Medical Association was held in Los Angeles, December 2 and 3, and was generally acclaimed the best yet.

Keynoting the Conference was an address by Dr. Louis H. Bauer, President-Elect of the American Medical Association, who spoke on "Working Together in '52". Stressing the need for action, Dr. Bauer pointed out that while Socialism has never worked anywhere, we continue to stray further and further from our democratic heritage. It was brought out that in the last national election, only 47% of those eligible actually voted.

The Sunday (December 2) afternoon session was featured by a panel discussion of "What Do People Think". Ernest Dichter, Ph.D., New York, stated that many patients feel like outsiders and complain that the physician never takes them into his confidence.

Edgar A. Schuler, Ph.D., Wayne University, found that in the Toledo area the public was overwhelmingly in favor of emergency and night call service. He found that the greatest sources of concern were fees, shortage of hospital beds and the possible shortage of doctors.

Larry Rember, Public Relations Field Director of the A.M.A., reported on a survey conducted in Decatur, Illinois, and mentioned hospital bills as the really big complaint. The average citizen also complained about the lack of community interest on the part of the physician. Mr. Rember pointed out that very few people had heard or knew very much about the Macon County Medical Society. The majority of those interviewed had heard of the American Medical Association but knew little about its activities.

The first panel discussion heard on Monday, December 3, was concerned with "The Cost of Sickness". Dr. Harlan English, Danville, Illinois, thought the wise physician would do well to inform the patient of fees beforehand and ask for any comments. He strongly recommended the A.M.A. plaque "To All My Patients" and asked for consideration and understanding. Dr. English felt that many of our present-day troubles can be traced to the day religion and faith began to be excluded from our government many years ago, bringing about a moral collapse.

Dr. Cyrus W. Anderson, Denver, suggested that physicians explain certain routine measures and especially repeating costs, such as blood tests, etc. He emphasized that many patients do not understand why there is a post operative examination of tissue, etc.

An interesting paper entitled "Time is Money for Your Patients, Too" was prepared by Dr. Stanley R. Truman, Ventura, California. Dr. Truman believed the idea of "first come, first served", was obsolete, and that good scheduling is all important. He emphasized that secretaries and nurses can be of great help in this connection.

"The PR Factor in Collecting Bills" was the subject covered by the next panel. Mr. Stanley R. Mauck, Columbus, Ohio, said that billing delays, misunderstandings, and bills sent to wrong parties were principal causes of unpaid bills. 63% of these unpaid bills can be traced to poor PR and business methods in the physician's office.

Dr. Joseph F. Donovan, San Jose, California, told of the free medical care for any not able to pay as advertised by the Alameda County Medical Society. While a surprisingly low number of inquiries were received, public relations have become very good.

A luncheon speech by Dr. Lewis A. Alesen, Los Angeles, proved to be one of the highlights of the Conference. Dr. Alesen attacked those who would lead us into Socialism and called for clear thinking and positive action by the medical profession with regard to the present-day political scene.

"Joining Forces with Other Groups" was the subject treated by the first panel on the afternoon program. Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association, stressed the need of contact and liaison with such organizations as the American Legion, etc. They must be told who we are, what we do, and what we believe.

The value of the physician participating in com-

munity affairs was cited by Dr. George Schwartz, New York, in an interesting account of conditions in the Bronx.

The final panel dealt at length on the question "Where Do We Go from Here?". Mr. Leo Brown, Director of Public Relations, A.M.A., resolved to work closely with organizations whose aims are similar to our own.

Those physicians who give freely of their time and money in the interest of PR were lauded by Dr. Joseph E. Mott, New Jersey. He also advocated closer cooperation with Blue Cross and Blue Shield, and recommended the immediate establishment of speakers' bureaus on the local level.

Dr. Charles R. Henry, Little Rock, Arkansas, closed the Conference with a plea that physicians discard their apparent disinterest and aloofness and go all out to insure the success of the local society, the state society, and the American Medical Association.

R.I.H.

Department of Clinical and Medical Education

A meeting of the Department of Clinical and Medical Education, Dr. C. Lydon Harrell presiding, was held in Richmond on November 15, 1951, at the Society Headquarters. Present were Dr. Harrell, Dr. Joseph W. Chinn, Dr. Mary Elizabeth Johnston, Dr. Kinloch Nelson, Dr. Mack I. Shanholtz and Mr. George Zehmer.

Dr. Harrell opened the meeting by reviewing the financial situation, and indicated that additional funds were needed if the work of the Committee was to be continued. The matter of an additional appropriation was to be placed on the agenda of the Council meeting in December.

A brief history of the post-graduate program in Virginia was given by Dr. Nelson, bringing all members of the Committee up to date in Committee activities.

The question of financing programs over the state was discussed and several suggestions were made for a better and more equitable method of promotion, calling for close cooperation between the local medical society, The Medical Society of Virginia, and the interested association (Heart, Cancer, Polio, etc.).

Mr. George Zehmer reported the progress of the Virginia Cancer Society, and stated that $40,000.00 was being made available to sponsor a state-wide symposium, dealing with treatment and detection of cancer. This program would be sponsored and administered by The Medical Society of Virginia if the Department of Clinical and Medical Education accepted the responsibility.

Mr. Zehmer went on to report that the services of Dr. Spencer, United States Public Health Service, had been secured in connection with this program, and he would be available by March 1.

The need of a Committee secretary was discussed, and Dr. Nelson was unanimously elected.

Also brought forth was the need for a central control point, and it was the opinion of the Committee that as much of the administration as possible should be handled by the executive office of The Medical Society of Virginia.

The Clinicopathological Reports as published in the *Virginia Medical Monthly* were discussed, and the concensus was that they are definitely a part of post-graduate education and should be continued. However, the Committee did not feel obligated to pay for additional cuts used in connection with the reports, and recommended that the expense be borne by the Society.

XUM

MENTAL HEALTH

JOSEPH E. BARRETT, M.D.,
Commissioner, Department of Mental Hygiene and Hospitals.

The Private Psychiatric Hospital*

In the United States the development of the private psychiatric hospital has about paralleled the growth of the public hospital. Dr. Nehemiah Cutter of Pepperell, Massachusetts, was one of the outstanding pioneers in private institutional work. In 1834 he built a large building and "received patients into his family". It is obvious that institutions of this type were looked upon with a good deal of suspicion, for in Dr. Cutter's obituary notice it is recorded that "he maintained the reputation of his institution unimpaired in spite of the prejudice against private asylums". More private institutions evolved by the conversion of a private home or estate into a private sanatorium. This is particularly true in Virginia and the Carolinas. Another natural development of course was that private sanatoria sprang up in the vicinity of urban areas and served people of property who wanted private care. Then, too, those who sought private care felt that they were avoiding some of the stigma, unfortunately, attached to mental ills. In the early days there were no regulations of private hospitals such as existed in the state system; hence, there was danger of abuse in this type of private psychiatric practice. In recent years this danger has been overcome largely in most states, including Virginia, by a system of inspection and license, which affords protection for both the patient and the institution. It can be categorically stated that no institution, public or private, is any better than the staff that operates it.

Of the 1,217,154 patients comprising the average daily hospital census in the United States (1948 figures), 664,399, or 54%, were patients in nervous and mental institutions. Approximately 97.7% of this 664,399 patients were in public hospitals, about 2.3% were in private psychiatric hospitals. This figure, 2.3% (nation wide) is relatively true in Virginia and the Carolinas. In Virginia there are more than 12,000 patients in the State hospitals as against approximately 350 in private hospitals or sanatoria. About 50% of these 350 patients are from outside the State. This leaves approximately 175 patients who are natives of Virginia. In other words, slightly over 1% of more than 12,000 mentally ill in Virginia are treated in private psychiatric hospitals. It seems obvious that the major role of the private hospital is to furnish care and treatment for one percent of the psychiatric population who wish and can afford private care. Another major role of the private hospital is to afford better care. This, fundamentally, is what the patient, or the family of the patient, is paying for.

When mental illness occurs in a family one of the first considerations is hospitalization—public or private. The economic status of the patient or family should determine whether or not public or private hospitalization should be sought, and the family physician should advise accordingly. Not infrequently the remark is heard that a private hospital will treat you until your money gives out and then transfer you to a State hospital. It is rare in the writer's experience that many go far beyond their means in private hospitalization; in fact, most operators of private hospitals are the first to advise public hospitalization and discourage the idea of taking on obligations beyond responsibility. More frequently we see patients transferred to public hospitals who can well afford private care. It should be clearly understood that no controversy exists between the public and private hospitals. Both have complemented each other in helping to raise the standard for better hospital care and treatment. The pioneers of private hospitals in Virginia have gained national recognition for their ability and achievements in the psychiatric field. The fact that many out-of-state patients seek hospitalization in Virginia's private hospitals lends emphasis to the State's progress in the psychiatric work, in which the public and private hospitals mutually share. There is no basic difference in the principles of care and treatment of a patient in a public or private hospital. The difference lies only in the ratio of hospital personnel to patients. This, of course, is what the patient, or

*This article prepared by Dr. Rex Blankinship, Medical Director, The Westbrook Sanatorium, Richmond, Va.

family of the patient, wants and pays for. The quality of service rendered by any hospital is determined by the caliber of the staff that operates it.

Do State and Federal hospital facilities threaten the existence of the private psychiatric hospital? What has become of the private tubercular sanatoria? During wartime accelerated industrial production and inflationary periods, it seems unlikely that private hospitals will suffer. In case of an economic depression the private hospitals would certainly have a tough pull.

Since the private psychiatric hospitals provide care and treatment for such a small percentage of the mentally ill, their independence should be encouraged. There is no good reason for the taxpayer to support, in a public hospital, one who can afford private care. The contrary is ridiculous unless we embrace the idea that we pay taxes at a high rate and therefore the State should take care of us.

In conclusion, it is believed that the private psychiatric hospital has a place in the community. We well recognize the fact that it would be impossible for the vast majority of people in the State to receive private psychiatric care, even if facilities for such care could be made available to them. The private psychiatric hospital should be continued and available to those who are able to afford such care. We must, however, as citizens and tax payers support the State institutions in order that they may continue to give the best of care and attention to the mentally ill who are unable to obtain private care.

Flora Eponym

GAYLUSSACIA

JOSEPH LOUIS GAY-LUSSAC (1778-1850)

Gay-Lussac, the distinguished French chemist and physicist, was born at St. Léonard, in the department of Haute Vienne. He was successively professor of chemistry at the École Polytechnique, professor of physics at the Sorbonne, and professor of chemistry at the Jardin des Plantes. In 1806 he was made an academician and in 1831 he was elected to represent Haute Vienne in the chamber of deputies. He was particularly interested in the chemistry and physics of gases and formulated the law of the heath family is a valuable ground cover in shaded, peaty places. G.brachycera gases at high altitudes.

Gaylussacia, better known as huckleberry or whortleberry, a fruitbearing species of the heath family is a valuable ground cover in shaded, peaty places. G.brachycera or juniper berry has small blue fruit. It is frequently confused with the blueberry, a species of *Vaccinium*.

XUM

EDITORIALS

A New Year's Plea for Understandable Medical Writing

WE HEREWITH make our New Year's protest against abbreviations in medical papers. We take it for granted that when a doctor, even if he be a Ph.D., writes a paper he wishes it to be read and understood, although it seems at times to be a form of exhibitionism on the principle that the less understandable the paper, the smarter the author. We do not believe that such is usually the case. Most authors write because they have something to say and if that is the case they should use every effort to be understood.

One of the commonest causes of incomprehensibility is the substitution of abbreviations for words. The laboratory worker has a group of letters for the various procedures and tests he uses; the clinician does the same for various syndromes; the endocrinologist speaks of new hormones by their initials instead of their names; the psychiatrist adds confusion with an entirely different set; and the military man combines with all the above a lot of camp jargon. This may be all right in conversation, where you can interrupt the speaker when you find he is getting beyond your depth, but for a reader of a medical journal it becomes hopeless.

Recently we came across an article that contained twelve new alphabetical abbreviations that could not be found in the latest medical dictionary. In most cases we could guess at the meaning, but in several we were entirely at a loss to know what the author had in mind. Granted that everyone knows by now what ACTH means, for example, we believe "adrenocorticotrophic hormone" looks better in print and carries with it a clearer concept than "ACTH". How many readers know what LAP or STH mean? Presumedly the author knows and it would take so little of his time to write it out, and it would add so much to the readers' enjoyment and understanding if he would do so.

The Twelve Commandments

THE Great Physician's only textbook was the ten commandments. He added two others. These twelve commandments are the finest example of precision prose extant. Also, they embody all the fundamentals of law and ethics. Grave them on your heart and you become a better doctor; a better citizen; and a better writer. If people would only live by them what a fine place this world would be!

The American Way

IN THE past year we have heard a great deal about the American Way. Just exactly what the term means probably varies with the person using the term. The Constitution guarantees to each of us life, liberty, and the pursuit of happiness. To most of us this means individual initiative, cooperation, assembly lines, mass production, and success. Along with this goes a restless, generous spirit, boastfulness, egotism, and sentimentalism. Work and worship formerly were important factors of the picture, but these have become outmoded. The welfare of the individual is the central idea of the American Way with no more State control than is necessary to safeguard his pursuit of happiness. Over emphasis is put on material things; automobiles, television, deep freezers, etc., and spiritual values are ignored. Political orators speak glibly about the freedoms which our ancestors came to achieve and for which they fought and died and which it is our duty to maintain. These varied considerably with the

thirteen original colonies. The one thing they had in common was the hatred of excessive taxes. This, you may recall, was the cause of the American Revolution.

We have become a luxury loving people, placing creature comforts above spiritual values. We have neglected the Church. Once a year we celebrate Thanskgiving. The rest of the year we seem unmindful of our blessings. The federal government has taken full advantage of our neglect of the Church and has embarked on a huge, expensive, politically controlled social program, a work that properly belongs to the various churches. The strange thing about the whole matter is that a great many churchmen seem to be in favor of the government's usurping their privileges.

The American Medical Association's Public Relations Plaque

MOST of the complaints the public has expressed of the medical service group themselves, on analysis, are about (a) its lack of availability and (b) its cost. Admittedly, the service in hospitals is superb, but in domiciliary practice it is becoming more and more difficult to get attention on holidays and at night. In an attempt to correct this condition, many local medical societies have appointed committees to see that certain officially delegated physicians are available for emergencies and calls at odd hours. In addition, the medical societies have appointed grievance committees to iron out misunderstandings that might upset good doctor-patient relations.

Rarely is there complaint of the service performed—at least until the bill is rendered. Public relations experts tell us that most of the complaints of the cost of medical and surgical care can be avoided if the doctor and the patient discuss the charges beforehand. In most places this is seldom done and, when it is done, the implication is that the medical man is making an unusual charge, and one that is too large. Furthermore, beforehand has not been considered a good time for such discussion for then the patient is sick and not in a mood to talk business. The doctor hesitates to broach the subject, for fear the patient will think that the fee, and not the welfare of the patient, is his greater interest, and so the subject is neglected. To encourage the patient to discuss the cost of non-emergency treatment before the service is rendered rather than afterwards, the Public Relations Bureau of the American Medical Association has prepared an attractive plaque to be exhibited in the doctor's office, advising his patients that the doctor welcomes such discussion.

Cat Scratch Fever

FROM Paris comes the news of a new disease, Cat Scratch Fever. It is a self limited disease, characterized by fever, a maculo-vesicular local lesion, and swelling of the lymph nodes, often with suppuration. Sometimes the fever is accompanied by chills. Laboratory tests are entirely negative. A skin-test antigen has been developed to which the patients react; the cats, however, do not react to this antigen. In fact, the cats that caused the disease do not seem to be affected in any way whatsoever. It is surmised that the cat carries the causative agent, whatever it may be, mechanically on its claws. A case has appeared in Boston and has been reported in the *New England Journal of Medicine* (April 12, 1951) by Greer and Keefer.

In this connection comes the report from Texas (J.A.M.A. **147**:949, 1951) of another curious disease, Aseptic Meningitis due to Leptospira pomona, a disease that comes from association with hogs. This patient had fever, headache, chills, and generalized aching. The headache, dizziness, and nausea continued after the fever subsided. Spinal fluid was cloudy with 980 cells, 86 percent of which were lymphocytes.

XUM

The authors, in their summary, predict, "As more agglutination tests for Lept. pomona are done in cases of iridocyclitis, aseptic meningitis, and influenza-like diseases, this pathogen will probably be found to be more frequent and widespread than heretofore believed." It would seem that Homo Sapiens should be more circumspect as to the company he keeps.

Navy Commander Herbert S. Hurlbut, Army Captain Robert M. Altman and Lieut. Carlyle Nibley, Jr. report that the Korean body louse is highly resistant to DDT.

SOCIETY PROCEEDINGS

The Williamsburg-James City County Medical Society

Held its Fall meeting October 26, after a dinner at the King and Kay Tea Shop in Williamsburg. The meeting was called to order by the President, Dr. B. I. Bell, who announced the resignation of Dr. Gordon Keppel as Secretary-Treasurer due to illness. Dr. Gordon's resignation was accepted with regret and Dr. Frances E. Wood was elected in Dr. Gordon's place.

Dr. Hugh G. Stokes, Chairman, reported for the Committee on Diabetes Detection Week. The committee had arranged for publicity in the paper and had made arrangements with the Superintendents of the schools for each child to take home a letter urging parents to have a urine specimen examined by the family doctor. Arrangements were made with President Chandler for the College of William and Mary students and faculty to be tested by the College infirmary, and plans were made for Eastern State Hospital to run their own tests. All doctors in the community were contacted and agreed to cooperate.

Dr. Granville L. Jones and Dr. Joseph E. Barrett, Delegates to the Medical Society of Virginia, gave their report on the meeting.

Dr. Andrew Davis and Dr. R. H. Hicks, dentist, both of Eastern State Hospital, were introduced to the Society by Dr. Jones, and were elected to Associate Membership until permanent licensure can be obtained.

FRANCES E. WOOD, M.D.,
Secretary

Wise County Medical Society.

Following a steak dinner at Hotel Norton on November 14, Dr. Lloyd L. Thompson, Jr., of Richlands, gave an excellent lecture on Neuro-alimentary Glycemia.

He was followed by Dr. James P. Williams, owner of two large hospitals in southwest Virginia, who spoke on Hospitalization in that section of the State. He reviewed the organization, development and pay plans from the old days of all private pay, through mine contract, then hospitalization contracts sold through a central agency for leading hospitals in the area. This served a fine purpose until administrative costs increased so greatly that hospitals had to abandon these contracts. Finally came outside insurance contracts, the Blue Cross and Blue Shield, and the United Mine Workers Fund, paying for the miners and their families. Most of the twenty-one doctors present had something to say or to ask about this live subject. The Hill-Burton aid in building two local hospitals was also discussed. Altogether, this was a most enthusiastic meeting.

In addition to these talks, there was a fine Wyeth movie of the highlights of the last National convention of the Academy of General Practice.

Delegate and alternate to the next meeting of the State Society were elected and it was voted to hold the next meeting at Norton on February 13.

Roanoke Academy of Medicine.

The December meeting of the Academy was held on the third, in the ball room of Hotel Patrick Henry. The guest speakers on this occasion were Dr. Stanley E. Bradley of Columbia University College of Physicians and Surgeons of New York City, who spoke on "Renal Insufficiency"; Dr. J. D. Meyers of Duke University, Durham, N. C., whose subject was "C. P. C."

Dr. Ira H. Hurt and Dr. Philip C. Trout are president and secretary of the Academy.

NEWS

The 1952 Meeting, The Medical Society of Virginia.

The Annual Meeting of The Medical Society of Virginia will be held in Richmond at the Jefferson Hotel, September 28-October 1, 1952.

A blanket reservation is being maintained for officers, guests, and delegates until February 1, after which time reservations for the general membership will be confirmed in chronological order.

Four hundred rooms will also be available at the John Marshall, Richmond, William Byrd and King Carter Hotels.

Southern Medical Association.

The meeting in Dallas in November, under the presidency of Dr. Curtice Rosser of that city, was splendid in very detail and had a registered attendance of 2,053 physicians, in addition to medical students, technical exhibitors and ladies, though there are always a number who fail to record attendance. Near the close of the meeting, Dr. R. J. Wilkinson of Huntington, W. Va., succeeded to the presidency for the coming year. Those elected to serve with him are: President-elect, Dr. Walter C. Jones, Miami; vice-presidents, Dr. Alphonse McMahon of St. Louis, and Dr. Frank A. Sellecman of Dallas. Mr. C. P. Loranz and Dr. M. Y. Dabney, both of Birmingham, continue as Secretary-Manager and as Editor of Southern Medical Journal, respectively. The next meeting is to be in Miami, November 10-13, 1952.

Virginia doctors who hold positions in the Southern and its various sections are: Dr. Waverly R. Payne, Newport News, member of the Council representing Virginia; Dr. George S. Fultz, Jr., Richmond, secretary, Section on Neurology and Psychiatry; and Dr. John B. Truslow, Richmond, secretary, Section on Medical Education and Hospital Training; Dr. A. Ray Dawson, Richmond, chairman Section on Physical Medicine and Rehabilitation; Dr. H. Hudnall Ware and Dr. W. C. Winn, both of Richmond, vice-chairmen, Sections on Gynecology and on Obstetrics respectively.

The Virginia Society of Anesthesiologists

Met at Virginia Beach on October the 8th. At this time, Dr. Albert V. Crosby of Norfolk stressed "The Role of the Anesthesiologist in the Small Hospital" and directed a discussion concerning the "Value and Advisability of Maintaining a Post-Anesthesia Recovery Room".

The officers of the Society who were elected at the annual meeting last March are: President, Dr. John Rosenthal, Norfolk; vice-president, Dr. Robert Morrison, Lynchburg; and secretary-treasurer, Dr. Harold F. Chase, Charlottesville. Dr. Rosenthal recently attended the annual meeting of the American Society of Anesthesiologists where he represented the Virginia Society.

The Society will hold its annual business meeting in Lynchburg, on Saturday, March 1.

Neuropsychiatric Society of Virginia.

The Fall meeting of this Society was held in the Richmond Academy of Medicine Building, Richmond, November 14, under the presidency of Dr. R. C. Longan, Jr., of this city. Dr. Walter Freeman of Washington, D. C., guest, spoke on "The Place of Psycho-Surgery in the Therapeutic Program of the State Hospital".

The next meeting will be held in the Spring at the University of Virginia, Charlottesville, in conjunction with the Regional meeting of the American Psychiatric Association.

Blood Needed for Servicemen in Korea.

Blood, urgently needed to save the lives of wounded servicemen in Korea, is being collected regularly in Richmond by the Red Cross.

A Red Cross Bloodmobile Unit will visit Richmond three days each in January, February and March. For each day's visit, 220 donors are needed. The success of the Blood Program here depends upon the community. Human beings are the only resource for this life-giving fluid so essential to saving our wounded.

Blood collected in Richmond is the city's share of the 300,000 pints of blood the Department of Defense estimates it needs each month to meet current military demands. Military surgeons in Korea have found that the average hospitalized casualty requires nine pints of blood in order to survive. This means that nine persons must give one pint of blood each in order to save the life of a hospitalized combat man in Korea.

Individuals in or near Richmond who wish to

XUM

donate a pint of blood are asked to telephone the Red Cross, 3-7451, for an appointment with the Bloodmobile Unit. If the Unit is unable to take an individual's donation this month, Red Cross will schedule the donor for a future visit.

Donors must be between 18 and 59 years of age and weigh at least 110 pounds. Women who are pregnant or who have been pregnant within the past year are not eligible. The Red Cross requires written permission from the parents or guardian of donors under 21 years of age who are not in Military Service and who are not married.

A visit to the Bloodmobile Unit requires from 45 minutes to one hour. After registering, the donor receives a medical examination including a hemoglobin test, pulse, respiration, blood pressure and 35 questions asked by the physician in attendance. With the physician's permission, the donor gives a pint of his blood. Afterwards he is served refreshments in the canteen and receives a pin in the form of a drop of blood as a symbol of his gift to the Armed Forces.

Dr. Frances A. Hellebrandt

Of the Medical College of Virginia has assumed duties as professor and head of the Department of Physical Medicine and Rehabilitation at the University of Illinois College of Medicine.

She also is serving as chief of Physical Medicine and Rehabilitation at the University of Illinois Research and Educational Hospitals. She has succeeded Dr. H. Worley Kendell, who has resigned as head of the department to accept a position as medical director of the Institute of Physical Medicine Rehabilitation at Peoria.

Dr. Hellebrandt formerly held the rank of professor of physical medicine and director of the Baruch Center of Physical Medicine and Rehabilitation at the Medical College of Virginia. She had been associated with the Richmond, Va., institution since 1944.

Watts Hospital Medical and Surgical Symposium.

For the ninth year, this Symposium will be held in Durham, North Carolina, and will be at the Carolina Theater on Wednesday and Thursday, February 13 and 14. This promises to be an excellent program and will include two days of papers, a clinico-pathological conference, and a panel discussion on Endocrinology. An outstanding group of speakers will include: Drs. Shields Warren, George Van S. Smith and Hugh F. Hare of Boston, Mass.; Dr. Albert Faulconer, Jr., Rochester, Minn.; Dr. Frank E. Adair of New York City; Dr. E. C. Hamblen, Durham, N. C.; Dr. Edward C. Reifenstein, Jr., Oklahoma City; Dr. E. Perry McCullagh, Cleveland; and Drs. Nathan A. Womack and Charles H. Burnett of Chapel Hill, N. C.

The American Board of Obstetrics and Gynecology

Announces the election of Dr. John L. Parks, of Washington, D. C., as a member and Director of the Board. Dr. Parks succeeds Dr. Joseph L. Baer who has been vice-president of the Board for over twenty years and who has resigned.

Award for Outstanding Research in the Field of Infertility.

The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Massachusetts.

Dr. Claude Marshall Lee, Sr.

Has been appointed medical member of the United States Civil Service Examiners, The Emergency Center and Ft. Belvoir, Ft. Belvoir, Va.

American Student Health Association.

The meeting of the Mid-Atlantic Section of this Association, composed of college physicians from Maryland, District of Columbia and Virginia, was held in Richmond, December 7, twenty-five physicians attending. Dr. Andrew D. Hart of the University of Virginia, Charlottesville, was elected president, Dr. Cullen Pitt of University of Richmond vice-president, and Dr. Frank R. Smith of Johns Hopkins University, Baltimore, secretary-treasurer.

Diabetes,

The Journal of the American Diabetes Association, is a new Journal, which will appear bimonthly be-

ginning with the January-February 1952 issue, and will be devoted to clinical and research reports on diabetes and related aspects of medicine. It will be the Association's official scientific and organizational publication, replacing its annual PROCEEDINGS and its quarterly DIABETES ABSTRACTS, both of which have been published for the past ten years.

DIABETES will be edited by Frank N. Allen, M.D., of the Lahey Clinic, Boston, Mass., first vice-president of the American Diabetes Association. Doctor Allan will be advised and assisted by a distinguished Editorial Board under the chairmanship of Charles H. Best, M.D., of the University of Toronto, co-discoverer, with the late Sir Frederick Banting, of insulin and its use in the control of diabetes.

According to Doctor Best, "The major purpose of DIABETES will be to give the medical profession and particularly the practicing physician, information which will help him to improve the treatment of diabetes and allied disorders.

The subscription rate for the Journal will be $9.00 a year for non-members of the Association; members will receive it without charge. Correspondence concerning both editorial and business matters and manuscripts of interest to the Editors, should be addressed to the Editorial Offices, DIABETES, American Diabetes Association, Inc., 11 West 42nd Street, New York 18, N.Y.

The Atlantic Coast Line Railroad Surgeons' Association

Will hold its 48th annual meeting at the Fort Sumter Hotel, Charleston, South Carolina, January 24-25. Visiting physicians are welcome and there is no registration fee. Among the speakers will be: Dr. Joseph S. Stewart, Miami, President, Southeastern Surgical Congress; Dr. Sam Marshall, Lahey Clinic; Dr. Elam C. Toone, Medical College of Virginia; Dr. J. S. Lyerly, Neuro-Surgeon, Jacksonville; Dr. John M. Harry, Chief of Surgical Staff Highsmith Hospital, Fayetteville, N. C.

It is recommended that reservations be made directly with the Hotel.

The Seaboard Medical Association of Virginia and North Carolina

Held its fifty-sixth annual meeting at the Cavalier, Virginia Beach, December 4-6, under the presidency of Dr. R. Bryan Grinnan, Jr., of Norfolk. An interesting program, scientifically and socially, had been arranged and the meeting was pleasant and instructive as usual. Dr. J. G. Ramsey of Washington, N. C., was unanimously elected president, and the vice-presidents are: Dr. J. M. Habel, Jr., Suffolk; Dr. Thomas P. Brinn, Hartford, N. C.; Dr. B. L. Parrish, Norfolk; and Dr. Edwin A. Rasberry, Jr., Wilson, N. C. Dr. L. Everett Sawyer of Elizabeth City, N. C., is secretary-treasurer. The Association voted to hold its 1952 meeting as guests of the Beaufort County Medical Society, the meeting to be held in either Washington or Elizabeth City, North Carolina.

Dr. I. S. Zfass,

Richmond, attended the Fourth International Congress of Mental Health held in Mexico City, December 11-19.

News from the Medical College of Virginia.

The eighteenth annual Clinical Session, postgraduate section in Ophthalmology and Otolaryngology, was held at the College, November 27-30. The series of lectures was sponsored by the Virginia Society of Ophthalmology and Otolaryngology.

Gifts and grants to the institution announced in November totaled $93,392. Grants were received from the United States Army, United States Public Health Service, American Foundation for Pharmaceutical Education, and the American Cancer Society.

A joint paper by Dr. E. I. Evans, Dr. G. J. Purnell, Jr., Dr. P. W. Robinett, Dr. Alastair Batchelor, and Dr. Mary Martin on "Fluid and Electrolyte Requirements in Severe Burns" was presented at the Southern Surgical Association at Hot Springs.

The regional meeting of the American College of Pathologists and the state meeting of the Virginia Society of Pathology and Laboratory Medicine were held at the Medical College, November 30 and December 1. A seminar on neoplasms was conducted by Dr. Frank Foote, Jr., of the Memorial Hospital Center for the Study of Cancer and Allied Diseases, and Dr. William Sunderman conducted a meeting for the evaluation of clinical pathology procedures.

Recent faculty promotions included Dr. Thomas Walker from assistant professor to associate professor of anesthesiology, and Mr. Sidney Kaye, from assistant professor to associate professor of legal medicine.

XUM

A State Medical Journal Conference

Was held in Chicago, November 12 and 13, at the American Medical Association Building. This was attended by editors, business managers, and others interested in editorial and mechanical make-up of journals. The various panels and papers discussed "The Job of an Editor", "Literary Aspects of Medical Journalism", "Mechanical Makeup of the Journals", "Financial Appraisal", "Problems of Business Management", "Socio-Economic Medical Articles" and "Medical Writing as Observed by a Reader".

The meeting was more or less a clinic in that it pointed out what is wrong with the average medical journal, how to improve it, what the readers like and the valuation of the different departments. Mechanical make-up of journals was discussed in detail, giving sizes and styles of type, and how these may be combined to make the journal more easily read. In the financial appraisal of journals, it was interesting to note that the *Virginia Medical Monthly* is among the few that was self-supporting.

The value of the scientific section of the journal was stressed. Most doctors only get one journal (probably the Journal of the American Medical Association) besides the state one and they need good scientific sections. Articles should be brief and to the point with an adequate summary, which must tell the conclusions which have been reached. State medical journals should be a medium in which ambitious young authors can publish their first articles and thereby really get a good start in being a good author. Priorities in publication should be given some special scientific research articles.

It was agreed by all present that this was a most instructive and necessary meeting, and it was announced they will be held every other year in the future. E.S.W.

Joint Meeting of Pathologists.

A joint meeting of the Middle Eastern Region, College of American Pathologists, and the Virginia Society for Pathology and Laboratory Medicine was held in Richmond on November 30. Dr. Frank L. Apperly of Medical College of Virginia presided. Papers were presented at both morning and afternoon sessions and a seminar on "Surgical Pathology of Certain Tumor Types" was conducted at the afternoon session by Dr. Frank W. Foote, Jr., associate pathologist of the Memorial Hospital, New York City. In the evening, the doctors had dinner at the Commonwealth Club at which Dr. William R. Bond, clinical research director of A. H. Robins Company, was speaker.

Dr. Geoffrey T. Mann of Richmond was chairman of the committee which prepared the program, and Dr. J. H. Scherer, also of Richmond, was chairman of the arrangements committee.

Office Space Available.

Doctor's or Dentist's office available immediately, corner Harrison and Franklin Streets, Richmond. Call 5-4397. (*Adv.*)

OBITUARIES

Resolutions on the Death of Dr. Wilson Elliot Driver.

Dr. Wilson E. Driver, whose death occurred on October 14, 1951, was one of the most prominent specialists in Eye, Ear, Nose and Throat, in the South. He was born in Driver, Virginia, on October 16, 1870.

After early education in local schools, he graduated from the University of Maryland's School of Medicine, in 1893. He later took a course at Johns Hopkins University, and became one of Norfolk's earliest specialists.

Dr. Driver was keenly interested in allergies and, as far back as 1900, he had his own laboratory working on the problems pertaining to allergic reactions.

During World War I he served his country as a Major in the Army, having volunteered as soon as the United States declared War.

He was a member of many medical societies, including the Norfolk County Medical Society, The Medical Society of Virginia, the American Medical Association, and the American College of Surgeons.

Dr. Driver is survived by two sons, Wilson E. Driver, Jr., of Norfolk, and Robert B. Driver of Sao Paulo, Brazil, with whom he visited after his retirement from private practice 8 years ago. Also he is survived by his daughter Mrs. Lemuel Shepherd.

Whereas, Norfolk has lost an outstanding physician and a member of this community, BE IT RESOLVED:

That these resolutions be entered in the minutes of the Norfolk County Medical Society, and a copy of same be sent to the Virginia Medical Monthly, and to the family.

Committee:

N. G. WILSON, M.D.
C. L. HARRELL, M.D.
A. A. BURKE, M.D., *Chairman.*